MATERNITY CARE IN ACTION

PART 1–ANTENATAL CARE

A guide to good practice
and a plan for action

First report of the
Maternity Services Advisory Committee.

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MATERNITY SERVICES ADVISORY COMMITTEE

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FOREWORD

BY THE CHAIRMAN

The Committee was established by the Government in accordance with a recommendation of the Social Services Committee in its report on perinatal and neonatal mortality[1]. Its establishment reflected concern at the rate of perinatal deaths which, while improving, still compared unfavourably with some other advanced Western countries. There was also concern at the wide variation in mortality rates between different parts of the country and different social groups. There were in addition numerous consumer complaints about the so-called impersonal nature of care in hospitals, where maternity services are now concentrated.

This is the first occasion for some years that the problems of our maternity services have been considered at a national level with all the professions concerned. Drawing on the collective experience of its members, the Committee is in a unique position to set authoritative guidelines which no profession acting independently could match.

The Committee decided at the outset that it would not repeat the work already done in this field, notably that of the Social Services Committee, in taking evidence from interested organisations, as there was already ample material available on which to base its conclusions.

The Committee, which includes representatives from both England and Wales, was first asked to deal with antenatal care, but expects to go on to consider other aspects of the maternity services, such as care during labour and in the postnatal period. Pre-conceptional care must also be considered.

The professions represented on the Committee are unanimous in their view that a major problem is the sheer volume of work which hospitals now attract. It has been suggested that many of the criticisms of the service would be met if a proportion of the work could be undertaken in clinics elsewhere. There is a clear need to examine whether all antenatal attendances contribute to the welfare of mother and baby and whether the professionals—particularly the midwives—are being used to the full extent that their qualifications and skills make possible.

The Committee has taken note of many examples of good practice but concludes that nonetheless no health authority can afford to be complacent and that a closer examination of the service provided could lead to significant improvements and greater satisfaction for the women and the professions concerned.

The Committee is mindful of the financial pressures on health authorities, and recognises that in the last analysis change can only come about by local agreement. It considers, however, that many improvements could be made by changes in attitude and reorganisation of procedures which would not involve additional

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[1] House of Commons Social Services Committee, Session 1979–80, Second Report: Perinatal and Neonatal Mortality. London, HMSO, 1980. 663–I.

expenditure. Other changes would require increased expenditure. What it has attempted to do is to provide authoritative guidelines to good practice, and to suggest ways in which health authorities and the professions can examine their present activity, mainly with a view to making the best use of the skills and resources available in hospitals, community services and general practice in order to provide a more personal and satisfying service for all concerned. It will be for each health authority to evaluate any change.

The report recommends lines of action for both the professions and health authorities, as the Committee believes that real improvements will only be achieved with the combined thrust of the professions, authority members and officers, their professional advisers, the Family Practitioner Committees supported by the Community Health Councils and users of the service.

Although this is only the Committee's first major task, as we still have before us consideration of care of the woman during the confinement and postnatally, and for her newborn baby, I cannot let this phase pass without putting on record my thanks to Committee members for the whole-hearted way in which they have all contributed to the Committee's work, and co-operated with each other and with myself with the single object of pointing the way in which improvements can be made in our antenatal services. I am indebted too to the Department's observers and the secretariat for the never-failing support they have given the Committee, and for their wisdom, energy, and patience in developing the agreed record of our deliberations which follows.

ALISON MUNRO

CHAPTER 1: INTRODUCTION

1.1 When we were invited to form a Committee to investigate the maternity and neonatal services Ministers suggested that antenatal care was the subject in most urgent need of consideration. There was also a groundswell of consumer dissatisfaction which had become apparent through a number of channels. Antenatal care was often provided in poor environmental conditions and without the continuity of personal care that every woman should receive. Consequently, many women were reluctant to attend clinics.

1.2 This was particularly disturbing because of the association between the lack of antenatal care and perinatal mortality. The matter was plainly urgent and at our first meeting we decided that our advice on antenatal care should be issued as soon as possible, before moving on to consider other aspects of the maternity services.

The aim of antenatal care

1.3 The aim of antenatal care must be to ensure as far as possible the health and wellbeing of the woman and the unborn child. Pregnancy and childbirth represent a physical, psychological and social change for the prospective parents, particularly the woman, and antenatal care should provide support and guidance at this time and help them to prepare for parenthood. Some at least of the impressive fall in maternal and infant mortality in the last two decades can be attributed to the increase in the provision of antenatal care, and to the level of specialist care provided.

1.4 Good clinical care however must be sensitive to the emotional needs and the rights of the mother, the father and their other children. In the majority of cases pregnancy is uncomplicated. It should be recognised that normally a pregnant woman is a healthy woman. All women need a service which treats their questions sympathetically. Additionally many need help with practical problems resulting from the pregnancy, as well as reassurance in the large majority of instances when these do not have serious implications. Intensive support and care is appropriate only for a minority.

The pressure on clinics

1.5 During the last two decades increasing public and professional expectations of the maternity services have led to a relatively uncritical expansion of hospital antenatal clinics and associated services. Critical appraisal of the function of antenatal clinics, particularly those in the hospital, and the roles of the various health care professionals involved is overdue. The obstetrician is a scarce resource; the skills of the consultant team should be devoted primarily to the care of those women in greatest need of specialist advice.

1.6 There is a need for greater flexibility in the use of the professions who undertake antenatal care, and in deciding where it should be carried out. The greatest need is to provide an integrated specialist and community service and to identify the contributions which can best be made by various branches of the service. Integration must be real; achieving this will require hard work on the part of each of the professions concerned and a willingness to co-operate closely to ensure that their separate skills are jointly deployed to the greatest possible benefit to the woman and her unborn child.

1.7 While recognising the excellent work done in hospital antenatal clinics, our concern is that they are being over-burdened by the large number of women attending. One result is that staff may concentrate on the routine physical examination at the expense of their other functions, which include providing women with information and practical advice on a personal basis, and listening to and answering their questions. A lack of time for this function is a particularly serious omission for those women who are socially and economically disadvantaged.

1.8 There is a need too for a more flexible approach to women and a more sensitive assessment of their individual wishes and needs. Rigid authoritarian attitudes should be a thing of the past. Antenatal care should reduce stress and anxiety, not add to it, and it should therefore be provided, wherever possible, in easily accessible surroundings where women can feel at ease and have privacy.

1.9 Early and regular antenatal care is essential for both the woman and her unborn child. Success is dependent on the collaboration of all involved, including the prospective parents. All must have a clear understanding of their respective roles and all professionals should be given the opportunity to work to the highest level of their competence.

Effective use of midwives' skills

1.10 In particular, midwives are trained to give care and advice throughout pregnancy, including the detection of abnormal conditions and their referral for medical advice where appropriate. Neglecting to use these skills, or their ineffective use, results in low job satisfaction for midwives, wastes financial and manpower resources, and ultimately leads to a poorer service to pregnant women.

Guide to good practice

1.11 We have aimed to provide a brief guide to good practice which puts an obligation on health authorities to examine with all concerned the way antenatal care is provided locally. It should ensure that, where necessary, the balance is redressed to encourage the provision of all the components of good antenatal care, including the supportive elements which are necessary to encourage attendance and reduce stress. The possibilities of improving even a well run system should not be overlooked.

1.12 Improvements also depend on the awareness, initiative and example of senior medical and midwifery staff. We look to the professionals concerned to examine the service in their district against this guide, as so much depends on the ability of all involved to reach clear agreement on the most suitable service to cater for local circumstances.

Local Maternity Services Liaison Committees

1.13 Health authorities should bring together all the professions involved by the establishment of a local Maternity Services Liaison Committee with adequate representation of all groups, to ensure integration between the specialist and community services. Each Committee should have two functions, the agreement of generally applicable procedures and the monitoring of the effectiveness of these procedures as they apply to the individual woman. It may well be that such a committee will wish to meet in two forms: as a professional group for its strictly clinical functions and with a wider membership for its more general business. Lay membership is desirable for the latter function but clearly not appropriate for professional tasks such as the clinical audit of perinatal deaths.

A plan for action

1.14 This guide has not been produced as an academic paper: *it is a plan for action*. We acknowledge the wide variation in needs and circumstances at local level, and there cannot therefore be one ideal solution which will fit every situation. Health authorities should review the service they provide to see what improvements can be made, and whether the deployment of skills and resources needs to be altered; and at the same time the organisations representing the professions should ensure that this guidance is disseminated widely.

1.15 Having discussed a number of options we have drawn up a checklist of questions at the end of each section. Every organisation and professional concerned with providing antenatal care should examine their service critically against this checklist, bearing in mind the central concern for the woman and her child. We welcome the recent initiatives by the professions to examine their own standards and objectives, in particular those of the Royal College of Obstetricians and Gynaecologists[2], and the Royal College of Midwives and the Health Visitors' Association[3]. Progress will depend on co-operation amongst everyone concerned (health authorities, professionals, user interests, Family Practitioner Committees, Local Medical Committees).

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[2] Report of the RCOG Working Party on Antenatal and Intrapartum Care.
[3] Joint Statement by the RCM and HVA on Antenatal Preparation.

CHAPTER 2: CONFIRMATION OF PREGNANCY AND INITIATION OF CARE

Policy statement

2.1 If a woman is to derive the full benefit from the antenatal services, she needs to confirm her pregnancy as soon as possible. It is important for her to receive early advice on health matters such as diet, smoking, alcohol or drugs and for those responsible for her care to have the best opportunity to establish accurately the period of gestation. There should therefore be immediate access to diagnostic facilities for professional confirmation of pregnancy in places that are well known to women, are readily accessible and have a welcoming and understanding atmosphere.

The general practitioner service

2.2 Most women go to a general practitioner for confirmation of pregnancy and to make arrangements for subsequent antenatal care. The advantages of continuing personal contact with their own doctor are clear. The general practitioner, in turn, is best placed to help the woman make the appropriate choice and put the next stages of antenatal care into immediate effect.

Delays in receiving care

2.3 However, a significant number of women who do seek care early, encounter delays in the system. Whatever the reasons for this, we are unanimous in deprecating any delay in initiating care. The general practitioner's awareness of the obligations and importance of good initial management is fundamental to every woman's care. Professional training and administrative arrangements should aim to eliminate delays.

2.4 A second group are those who do not seek professional advice until their pregnancy is well advanced, of whom some receive no antenatal care at all. Reasons for not seeking antenatal care vary: a few women, often those most at risk, do not wish to admit they are pregnant. Others may not wish to approach their doctor, or from past experience do not see any benefit in receiving antenatal care. Recent immigrants or those without a settled home may not be aware of the facilities available from the health service, and there are some who do not speak English, or who are inhibited by religious customs from seeking advice.

2.5 Local and national campaigns to inform the minority groups of their rights to the existing services may be enough to solve this problem in many cases. A different type of approach is required for women who are not registered with a

doctor in the locality and for those women who are unwilling to approach a general practitioner or a hospital antenatal clinic. Health visitors and other members of the primary care team should play a greater part in ensuring early contact with the services.

Alternatives to the usual antenatal services

2.6 Health authorities will need to examine the extent to which alternative access to confirmation of pregnancy is needed in their district, and subsequently to consider which arrangements would be most likley to achieve maximum takeup of the service. Options could include walk-in clinics run by midwives and health visitors. These could be held at times other than normal clinic hours, ideally on a set evening(s) or on a Saturday morning. Such an arrangement would be particularly attractive to working women. Special arrangements might also be helpful for groups with particular needs, such as teenagers and ethnic minorities.

2.7 Completely confidential pregnancy testing facilities should be available in family planning and well-women clinics. In these clinics women with confirmed pregnancies would be advised on further care. They should be encouraged to register with and seek advice from a general practitioner if they have not already done so.

2.8 Places where women may seek confirmation of pregnancy should be well publicised, to reach as many women as possible. The use of health education has already been mentioned in relation to local ethnic minority communities. Health authorities will need to ensure that other sections of the community are aware first of how to become registered with a general practitioner and where pregnancy confirmation services are provided and, in addition, for those who have no general practitioner or are reluctant to attend one, the other means of obtaining a pregnancy test. Health education should also alert women to the importance of early confirmation and of early assessment of the duration of the pregnancy.

"Do-it-yourself" pregnancy testing kits and pharmacy tests

2.9 Although health service facilities are available, it is likely that some women will wish to approach their pharmacy for a test or for a "do-it-yourself" kit, as their first step. The pregnancy test kits are unfortunately not always reliable in unskilled hands, and even if used correctly, professional confirmation is advisable, as false positive and negative results do occur. The kits include some advice to women about smoking and the use of medicines in pregnancy but it would be helpful if further advice were given in local pharmacies on the need to contact a doctor or a midwife.

2.10 Tests performed by pharmacists do not carry the same risks of false results, but it is important that each woman, regardless of the result of each test, should be given advice on seeking professional help if she thinks she is pregnant and also given information on the local antenatal facilities.

ACTION CHECKLIST A

CONFIRMATION OF PREGNANCY AND INITIATION OF CARE

A. Health authorities will need to assess the extent of and reasons for late attendance in their district, and consider the solutions likely to increase the early uptake of care locally.

A.1 Are there facilities available to enable any woman who thinks she may be pregnant to obtain early professional confirmation of her pregnancy?

A.2 Are facilities for confirming pregnancy being made readily available to general practitioners and midwives?

A.3 Are general practitioners responding promptly to requests for confirmation of pregnancy and planned antenatal care?

A.4 Is education on the value of early confirmation of pregnancy reaching all health professionals?

A.5 Is the waiting time for a first hospital appointment less than two weeks, and less than one week for any woman in the second trimester?

A.6 Are significant numbers of women not registered with a general practitioner? If so, is an effort being made to inform people about the need to register, and how to do so?

A.7 Is there evidence that women are reluctant to approach their general practitioner for a pregnancy test? If so, are there health service alternatives available, with open access to pregnancy tests?

A.8 Are such facilities readily accessible—eg in family planning clinics, other local premises, hospital and health centres, and are these open in the evening and on Saturdays? How widely are such facilities publicised?

A.9 Do local health education programmes on antenatal services stress the importance of early confirmation of pregnancy?

A.10 Do services take account of the diversity of cultures, languages and social and economic circumstances in the district and make appropriate provision for special groups?

A.11 Have health authorities considered the need for information (including leaflets prepared locally) about where to seek antenatal care? Is such information made available to women who buy pregnancy test kits or request tests from the pharmacist?

CHAPTER 3: THE INITIAL ASSESSMENT

Policy statement

3.1 Every woman should have available to her good quality antenatal care, always subject to revision if her circumstances or condition should change, and taking full account of her wishes.

3.2 Once her pregnancy has been confirmed, each woman needs to discuss the pattern of antenatal care most suitable for her, and the alternatives available to her in choosing the place of delivery. She can only be advised on these matters after a thorough assessment of the medical and social factors likely to affect the course of her pregnancy. In most instances general practitioner, consultant obstetrician and midwife will all be involved in this. This assessment should take place as soon as possible after the pregnancy has been confirmed so that appropriate care can be offered from the earliest days of pregnancy.

3.3 The woman's first encounter with a service that she is to use regularly in the ensuing months will be crucial both in setting the tone and in deciding the best plan of care throughout pregnancy, delivery and the postnatal period. It is also an important occasion for her to ask questions about any aspect of her condition and to express her own worries and views about the course of the pregnancy.

3.4 Wherever she is seen, the woman's response to her initial visit will affect her readiness to take up the care available, to act on advice given, and also to feel secure in seeking answers to her queries. The clinic should be welcoming, and well organised; it should not increase stress by long waiting periods in uncomfortable surroundings, before being seen by overworked staff with neither time nor privacy for discussing any problems.

3.5 We deprecate arrangements where women are asked to make separate visits for booking, consultation and investigation. With careful organisation it should be possible to arrange these for the same day.

3.6 The first visit should provide an opportunity for the woman to meet members of the health care team with whom she will be in contact throughout her pregnancy. The woman should leave the clinic feeling that she has been treated as a responsible partner who can play an important part in what lies ahead, and whose wishes will be respected. She should be quite clear about all the services available to her and how to obtain them, and when and where her next appointment is.

Who should carry out the initial assessment

3.7 It is a matter for local agreement between the professions who should carry out the initial assessment, and where it should take place. While in some areas it may be agreed that only women in certain categories need to be referred to a consultant, in others the accepted practice may be for all women to be referred by the general practitioner, or, exceptionally, some women may be seen first at the hospital.

3.8 Whatever procedure is used, it is important that clear guidelines should be developed in each district on how to organise effective shared care, and in what circumstances provisional plans should be revised. For those women whose care is undertaken by the general practitioner and the midwife on their own responsibility, a consultant view of the most suitable plan for individual management of pregnancy and labour will only be available by referral.

Risk factors

3.9 It will be for the professions to agree locally which groups of women require consultant supervision. The initial assessment should provide standard data on which to base this decision. The use of a risk checklist has proved valuable in some centres. One nationally agreed checklist would not be appropriate. Locally agreed checklists are more likely to be understood and therefore used, and their development and testing will be a mutually educative experience for the professionals concerned. Such checklists might cover important items like age and parity, height and pre-pregnancy weight, medical, surgical and obstetric history and predictive items such as smoking, alcohol consumption and diet. Other information might include the occupation and place of work of both parents and their living conditions. The danger with checklists of this sort is that if applied mechanically the unexpected can be overlooked. The list, and the related protocols for management of identified risk factors, need to be kept under continuous review.

3.10 Health authorities will need to provide sufficient flexibility in their antenatal service to meet the different needs of women considered to be at risk. We see the following broad categories as having different needs.

3.10.1 **Women with a predicted high risk in pregnancy and labour.** This might be due to obstetric causes, eg a history of spontaneous abortion, premature labour or low birthweight infant, stillbirth or neonatal death; or to medical causes, such as diabetes or hypertension.

These women need specialist supervision of pregnancy and labour with delivery in a consultant maternity unit.

3.10.2. **Women with a predicted high risk in labour,** eg those with a contracted pelvis or where a multiple pregnancy or malpresentation is discovered during pregnancy.

Provided no additional problems arise, these women do not require specialist antenatal care throughout pregnancy, but specialist care should be arranged for the confinement, including the timing of possible intervention, eg Caesarean section.

3.10.3 In both of the preceding categories, where clinical decisions affecting the management of pregnancy or labour concern paediatricians or anaesthetists their early involvement is essential.

3.10.4 **Women whose circumstances increase their level of risk in pregnancy,** eg heavy smokers, those with alcohol or drug-related problems, poorly nourished women, and those in difficult home circumstances, particularly unsupported women.

These women require sympathetic and practical help designed to modify these risk factors and give continuing support. While the help required is more intensive than for women without these problems, the consultant clinic may not be the best source of help for this group, as they do not necessarily have any medical difficulties. The services needed by women in these groups should follow a less medical model unless other factors are also present.

Women who have previously had a baby which died in the post-neonatal period, or which was born handicapped, will need special understanding and care, including the opportunity of seeing a paediatrician antenatally.

3.10.5 **Women in other categories associated with higher risk** which include the very young or older women, those with large families and those from ethnic minorities, or from disadvantaged social backgrounds.

Special arrangements may be necessary to make antenatal care acceptable for these groups. The midwives and health visitors must make links with ethnic minority groups, and young single women living alone or in hostels or who are homeless, in order to build mutual confidence and understanding, thereby enabling a better use of services and better community support.

Particular attention must be paid to increasing the level of knowledge of the professionals about the cultural customs of the groups they work with. At all times every effort should be made to ensure that pregnant women are cared for sympathetically. Women staff may be more acceptable than men staff to some groups.

Older women may have particular problems in taking up antenatal care, for example family and work commitments, and previous experience may have put them off. Services should try to avoid increasing stress and anxiety, for example, if amniocentesis is under consideration. The increased risks which face some women in these categories may be because they experience the circumstances listed in 3.10.4, and they too might benefit from the intensive practical support which can be provided by general practitioners and midwives.

The plan for antenatal care

3.11 By means of their assessment the health professionals involved should have gathered all information necessary to describe the state of health of the

woman and unborn child and their likely needs. Each woman should be given clear advice about the antenatal care she is likely to need and her wishes should be discussed so that she can look forward to the next step in her antenatal care with confidence and understanding.

3.12 All women need advice on how to respond to changes which they may notice, and in particular what to do if various symptoms develop. They also need full information about how to recognise the onset of labour, and what to do when that happens. Everyone should know that if labour starts unduly early, the woman needs immediate professional advice.

Record cards

3.13 Many districts already use co-operation cards in addition to the records retained by the hospital or general practitioner. These cards provide a useful means of keeping all professional staff informed of the care provided by others. Cards should be fully completed at every antenatal visit, so that women know from the start the results of examinations and the time and place of the next appointment.

3.14 A method of ensuring that women are fully informed from the start is for them to keep their own record cards containing information on the results of the examination and the time and place of the next appointment—in other words she will know the agreed plan of management of her pregnancy. A few districts are testing the effectiveness of women carrying their own full antenatal medical records.

3.15 Any system which is decided upon must provide adequate data should the woman require attention in an emergency, be it a complication of pregnancy, other illness or accident if she is away from home.

3.16 In summary, we accord high priority to a simple and well-kept record system which will record vital information to which women and professionals alike will have ready access. Local Maternity Services Liaison Committees would be a suitable forum in which to reconcile the information needs of women, midwives, general practitioners and consultant obstetricians.

ACTION CHECKLIST B

THE INITIAL ASSESSMENT

B. The health authority will need to establish a locally agreed procedure for the initial assessment of the pregnancy, which is known and understood by all professionals.

B.1 Are many women having difficulty in attending antenatal clinics, because of location or timing? If so, would there be a demand for peripheral clinics, or evening or weekend clinics?

B.2 Are women sent simple and clear information before their first assessment at the clinic, giving details of its location, transport facilities and procedures to expect, with the likely time the visit will take, so that those with other children can be given suitable appointment times or make arrangements for their children? Are they advised of any facilities for young children at the clinics?

B.3 Content of assessment visit—is there a local agreement on standard information to be sought and tests to be taken at the first assessment, and on the advice to be given initially on such matters as smoking and diet?

B.4 Is there agreement on a standard way of recording the following:
- —estimated date of delivery?
- —previous obstetric and infant history?
- —relevant medical conditions?
- —haematological investigations, eg blood grouping, Rhesus factor, rubella status?
- —smoking, eating and drinking habits?
- —age, height and weight?
- —occupation of both parents?
- —home circumstances?

B.5 Are the woman's smoking, eating or drinking habits reviewed as necessary?

B.6 Does the classification of risk derived from these data identify those women medically and socially at high risk, and hence their different needs?

B.7 Is a plan for antenatal care then agreed with the woman concerned, taking account of the need to avoid unnecessary visits?

B.8 Does this plan include:
- —involvement of the father wherever possible?
- —an outline of the screening facilities available?
- —the opportunity to have early and continuing advice on nutrition?
- —help to overcome smoking habits, such as forming a smokers' group?
- —a home visit from the midwife and the health visitor?
- —parentcraft classes?
- —a visit to the maternity unit where delivery is planned?
- —an opportunity to discuss care in labour, including methods of pain relief, and to record the woman's wishes on this?
- —a record of any preferred length of postnatal stay?
- —encouragement to breastfeed, and advice on methods of infant feeding?

B.9 If required, is there a social worker or a welfare rights officer available to give advice?

B.10 Is the provisional booking for the confinement made after full discussion with the woman about her wishes and the procedures to be followed in labour?

B.11 Is there a record system which meets the mutually agreed needs of women, midwives, general practitioners and consultant obstetricians?

CHAPTER 4: SUBSEQUENT CARE

Policy statement

4.1 At the moment a large number of subsequent examinations, even for those women not in need of specialist advice, take place in hospitals. This has led to excessive demands on the consultant's team, and unsatisfactory conditions in the antenatal clinics. Long journey times are also a disincentive to attendance.

4.2 After her initial examination, the frequency of attendance and style of care will depend on each woman's circumstances, but the need for information and a trusting relationship with the staff will be constant. A high level of communication with the woman and among professionals is therefore essential, with clear agreement on the role of each group and a maximum amount of continuity of care. Otherwise considerable advantage for the woman will be lost.

Options

4.3 The pattern of antenatal care and the degree to which it is shared between professionals—consultant, general practitioners and midwives—varies amongst, and within, districts. In some places women receive antenatal care from their general practitioner or local midwife clinic unless there are specific medical grounds for referral to the consultant clinic, after which care may be shared. In others a system has developed of fully shared care between the specialist and primary care teams. In some places, especially in urban districts, all women continue to attend the consultant clinic for the greater part of their antenatal care after their initial attendance. In such cases the hospital clinics have often become overloaded with work, some of which might be handled at a local level to the advantage of both the pregnant women and the staff.

4.4 Where significant numbers of women have no doctor, or are reluctant to approach a general practitioner, open access to specified clinics organised by hospital units will need to be considered.

4.5 Irrespective of where care is to be provided, every woman should be visited by a midwife and a health visitor in her home.

Hospital consultant clinics

4.6 The hospital clinic is ideally suited to provide specialist care for women at high risk, and for those who require a consultant's opinion at any point during pregnancy. It is able to offer specialist facilities and undertake specialised investigations, familiarise the woman with the maternity unit and the staff who will be responsible for her care during labour, and provide health education for her special needs in pregnancy and labour. Hospital clinics should play an important part in establishing rapport between the woman and staff, acclimatising the woman to hospital and generally preparing her for admission and delivery.

4.7 In some specialised hospital clinics, and for some conditions, obstetricians may wish to share with consultants in other disciplines the management of pregnancy and the counselling of the parents. This could apply particularly to their colleagues in paediatrics, genetics, anaesthetics and general medicine.

4.8 The development of ultrasound, among other techniques, has enabled great strides to be made in the early detection of potential problems and the accurate assessment of gestational age. It is however essential that the philosophy of antenatal care inherent in this report, namely the need to communicate effectively and humanely with all pregnant women, should extend to the technicians who are involved in giving tests as well as to the medical and midwifery staff.

4.9 We recognise that work in antenatal clinics is an essential part of the training of junior medical and midwifery staff, in which they will undertake delegated tasks under supervision or independently. It will be equally necessary to ensure adequate supervision in peripheral clinics as in those held within the hospital. A guide to the organisation of hospital antenatal clinics is given in Chapter 5.

General practitioner care

4.10 Districts where general practitioners play an active role in antenatal care, and/or where there are midwife clinics inside or outside hospitals, can offer a flexibility of approach in providing antenatal care which is especially useful in dealing with low-risk pregnancies or those with non-medical problems. Such an arrangement allows consultant clinics to concentrate on those women in greatest need of specialist attention.

4.11 Antenatal care for women whose pregnancies are progressing normally may be undertaken efficiently by either the general practitioner or the midwife, provided that a locally agreed procedure operates to ensure easy transfer of care to the consultant clinic when necessary, and to eliminate duplication.

4.12 The increased interest of vocationally trained general practitioners in providing antenatal care, if not care during labour, is an encouraging development. We welcome the joint report of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners[4] on training in obstetrics and gynaecology for general practitioners. This emphasises the importance of maintaining skills by continuing to manage an adequate number of deliveries, of keeping knowledge up-to-date, and the important contribution to the training of junior colleagues which may be made in general practice.

4.13 The average general practitioner's list of 2,200 patients provides 20–25 pregnancies a year, some of which will require significant consultant assistance. Regular antenatal care for the remaining women should usually be organised without difficulty by a general practitioner on the obstetric list and a midwife

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[4] Report on Training for Obstetrics and Gynaecology for General Practitioners by a Joint Working Party of the RCOG and RCGP.

working closely together. Full access to the diagnostic facilities of the nearest consultant maternity department can ensure the maximum continuity of care in a familiar setting.

Midwife care

4.14 The midwife is qualified to assess both the health of the woman and the growth and development of her unborn child throughout the pregnancy. She is able to give comprehensive antenatal care, including clinical assessment, advice, information and emotional support. This includes the detection of abnormal and potentially abnormal conditions, and referral for appropriate medical advice and care.

4.15 We recognise that the under-utilisation of midwives' skills is common, and we see scope for more midwife clinics to be established. These clinics may be held in general practitioner surgeries, health centres or in hospitals, independent of medical staff for those women whose pregnancies are progressing without complications. Even where the condition of the woman or her unborn child does require medical supervision, the midwife's advice and support can still play an important part in helping the woman to cope with her natural anxieties. If women cannot or do not attend a clinic for their antenatal care the midwife may provide care in the home.

4.16 Organisation of integrated midwifery services in the community and in the hospitals should minimise the chances of antenatal care and delivery by strangers for the woman who is involved in a system of shared care.

Shared care

4.17 The majority of women whose initial assessment is made in the consultant clinic, and whose pregnancies are progressing normally will be suitable for shared care. A system of shared care among general practitioner, midwife and consultant can function very well, provided that care is properly shared, and not organised in unconnected compartments.

4.18 The frequency and content of clinic attendances should be reviewed regularly for each woman, to meet her needs. Care must be taken to keep all participants in the system properly informed, to avoid a situation where the woman is seen at ill-spaced intervals by a series of unidentified strangers all asking the same questions without any co-ordination or explanation.

4.19 A properly organised system of record cards with details of tests taken and dates of examinations should avoid duplication of effort but they are only effective if staff use them properly. It is also important that the records system should identify those women who do not attend, for whatever reason, and local arrangements should be made for these women to be followed up and for care to be provided in the woman's home if necessary.

4.20 Maternity Services Liaison Committees should explore ways of monitoring the effectiveness of local arrangements for shared care, whereby all professionals have the opportunity to discuss the requirements of each woman seen.

Peripheral clinics as an extension of the hospital service

4.21 The development of peripheral clinics where consultants and/or midwives hold antenatal clinics away from the main consultant department should be considered as a means of increasing the take-up of service, since a common reason given for non-attendance is the difficulty of reaching the hospital clinic. These difficulties arise not only in rural areas, but also in densely populated cities and other urban areas with inadequate public transport on which most women still have to rely.

4.22 Where peripheral clinics are run by a team of midwives, they should be free to refer cases direct to the consultant.

Educational preparation

4.23 Wherever antenatal care is given, women (and their partners, as far as practicable,) should be encouraged to attend classes during the antenatal period to prepare for the remainder of pregnancy, labour and the postnatal period. It is generally agreed that breast feeding should be discussed early in pregnancy, and frequently thereafter, if women are to feel sufficiently confident to persevere with breast feeding.

4.24 Classes should be arranged at times and in places which are convenient for as many as possible, but for groups of a size which permits discussion and participation by all present. The content and method of presentation should be reviewed regularly by midwives and health visitors together, taking into account the contribution that other professionals might make, so that the maximum benefit is obtained for local needs. Some women, eg the disabled and their partners, may require individual help to meet special needs.

4.25 Preparation for parenthood should deal with the realities of being pregnant, delivering and caring for a baby, how and when to seek advice and any emotional changes arising. A visit to the place of delivery should be arranged to include a tour and a discussion of the policies and procedures which may be met throughout the period of her stay and immediately after going home.

Procedures and screening tests

4.26 It is important that the reasons for procedures and tests and their results and meaning should be explained to each woman. She should be given the opportunity to decline tests. There should be no delay in passing on the results of the tests, and she should know who will give her this information.

4.27 Tests for foetal abnormalities in particular must only be undertaken with the woman's informed consent. Information about such tests should be available to all women receiving antenatal care. It is important that the reasons for the tests, the risks they might carry, and the options and significance if the result is unfavourable, should be explained to each woman.

ACTION CHECKLIST C

SUBSEQUENT CARE

C. Health authorities should ensure that local guidelines on the provision of antenatal care have been agreed by local Maternity Services Liaison Committees providing women with maximum flexibility and ease of access in the take up of a suitable form of care.

C.1 Do the local guidelines provide general practitioners and midwives involved with access to diagnostic facilities?

C.2 Is consideration given to minimising the number of professionals dealing with each woman, so making it easier for her to relate to the team providing care?

C.3 Is the care of each woman co-ordinated, to prevent duplication or omission of work?

C.4 Do those involved in the antenatal care of each woman discuss progress regularly?

C.5 Are meetings of professionals held regularly to review clinical practice?

C.6 Are those women who do not attend antenatal clinics followed up, and if necessary visited at home? Does the appointments system identify these non-attenders and bring them to the attention of staff who will take appropriate action?

C.7 Are women visited at home early in pregnancy to discuss suitable arrangements, and their future plans?

C.8 Has the development of clinics away from the main hospital site been assessed?

C.9 Are women encouraged to discuss their views on procedures in labour, and to express their preferences?

C.10 Are women given the opportunity to visit the maternity wards, with explanations of the procedures they can expect when admitted?

C.11 Are women given the opportunity to visit the special care baby unit if they wish?

C.12 Is there adequate provision for health education and relaxation classes?

C.13 Are these well publicised, with some arranged at times when working women or prospective fathers can attend?

C.14 Is there provision for one-to-one advice for those women with special needs?

Midwives' professional skills

C.15 Are midwives well known—is the way they can be contacted locally well publicised?

C.16 Can midwives be readily identified by women who want to seek their advice?

C.17 Are midwives used to the full extent of their professional expertise?

Procedures and screening tests

C.18 Is the woman properly informed of the reasons for recommended tests, and given the opportunity to decline them if she wishes? Is she told the results of the tests, and what they mean, as soon as they are available?

C.19 Are tests for foetal abnormality undertaken only for women who have chosen to have them?

C.20 Are technical staff aware of the need for a sensitive approach to the women for whom they undertake tests such as ultrasound? Have they been given guidance on who is responsible for giving women the results of their tests?

CHAPTER 5: ORGANISATION OF HOSPITAL ANTENATAL CLINICS

Policy statement

5.1 The good atmosphere, organisation and proper appointment system which are so important at the initial visit to the clinic should be maintained throughout antenatal care along with a continuing emphasis on providing continuity of care and reassurance to the woman from, wherever possible, a small group of staff who are known to her.

Access to other services within the hospital

5.2 Wherever possible, antenatal pathology and pharmacy services, obstetric ultrasound facilities and social work support should be provided in or adjacent to the antenatal clinic. Prescriptions should be valid for collection at the hospital pharmacy during or immediately after the clinic. Clear signposting to all departments is essential.

Reduction of waiting times

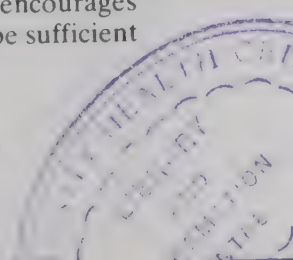
5.3 The organisation of a hospital antenatal clinic is a complex undertaking. The organisers need to recognise that time is valuable to the woman attending as well as to the staff, and waiting times before and between procedures should be kept to the minimum. The timing of appointments should have regard to her travel arrangements, and should be realistic in estimating the likely duration of each consultation. Appointment systems should be substituted where block bookings cause long waiting periods. Where the public transport system dictates that many of the women arrive together the aim should be to use their time productively.

5.4 Even when clinic attendances are reduced to the essential minimum there may be such a deficiency of clinic sessions or of space that overcrowding still occurs. It is the responsibility of the health authority to ensure that its allocation of clinic facilities takes full account of the need to eliminate overcrowding and to reduce to the minimum the delays for women who attend the clinics.

5.5 If the clinic is to run to time all staff must attend on time and give it their full attention, without other commitments.

Improving the atmosphere in clinics

5.6 Antenatal clinics should have a welcoming atmosphere which encourages women to approach the staff and to talk to each other. There should be sufficient



seats for all women who are waiting, with additional seats for any companions. There should be an area for young children to play under supervision while their mother is being seen. In some clinics women are reluctant to leave their seats in case their place in the queue is then lost. The system should be flexible enough to accommodate this, eg by giving each woman an indication of how long she is likely to wait. There should be easy access to lavatory and refreshment facilities.

Privacy

5.7 Privacy during examinations is essential and the woman should be able to put the questions which concern her without being overheard. Examination cubicles should be separate from public areas and students and relatives should only be present if the woman gives her permission.

5.8 Wherever possible, all examinations which involve undressing should be carried out at one stage in the visit, so that women do not have to sit in public waiting areas in hospital gowns. A secure place should be provided for clothing and valuables, where the woman does not keep these with her. Arrangements for collecting urine specimens should be discreet.

Continuity of care

5.9 It is important that the woman should be able to build up a relationship of trust with the staff she meets, and efforts should be made to involve the same group of staff at each visit. Staff should be easily identifiable.

ACTION CHECKLIST D

ORGANISATION OF HOSPITAL ANTENATAL CLINICS

D.1 Has an effective appointments system been organised to fit in with the local travel arrangements, and is each woman consulted about the time of her next appointment? Where large numbers of women attend is there a method of giving information as to how much longer they will have to wait, eg do they know whether it is their turn next or how many patients are still to be seen before them?

D.2 Is extra time allowed for the initial assessment visit?

D.3 Are checks made periodically on average waiting time and staff punctuality?

D.4 Have the clinic sessions within the hospital been organised to minimise unoccupied time eg, by regulating the numbers of women referred to ancillary departments?

D.5 Does the waiting area provide:

—sufficient seating for women and those accompanying them?

—a play area for accompanying children, with supervision while their mother is examined?

—access to refreshment facilities (without forfeiting position in the queue)?

—books, magazines?

—adequate toilet facilities, sufficiently large for women in the late stages of pregnancy?

—well designed posters and up-to-date health education material, encouraging women to ask questions freely?

D.6 Have local voluntary organisations been approached for assistance in giving the clinic a more welcoming appearance?

D.7 Does the examination area provide:

—secure accommodation for personal belongings?

—privacy for examinations with a suitable space for private discussions?

—discreet arrangements for collection and testing of urine specimens?

D.8 Is the clinic organised as far as possible to avoid women being kept waiting undressed or being kept waiting partly clothed between examinations?

D.9 Are all staff readily identifiable, both by name and function? If students are present, has the permission of the woman been given?

D.10 Are trained interpreters (staff or volunteers) available when necessary?

D.11 Does the clinic provide adequate accommodation for essential staff, such as social workers, dieticians and clerical workers?

D.12 Is each woman given a card recording all information relevant to the pregnancy, for reference by herself and by the professionals assisting her, and is its importance explained to her?

D.13 Are all departments clearly signposted, in colour codes for those with literacy problems?

D.14 Is the hospital pharmacy open to out-patients and does it remain open until after the antenatal clinic session has finished?

D.15 Having considered how the antenatal service can best be deployed in accordance with this report, has the authority allocated sufficient clinic sessional time and space for antenatal care to eliminate overcrowding?

CHAPTER 6: CONCLUSION AND IMPLEMENTATION

6.1 Each health authority, members and officers, their professional advisers, Family Practitioner Committee, Community Health Council and each profession concerned should consider this report and examine what action is appropriate to them. Action should be taken in keeping with the checklists in the preceding chapters.

6.2 Health authorities should establish a local Maternity Services Liaison Committee as recommended in paragraph 1.13 to review local arrangements and procedures, and to ensure the best use of the resource and professional skills available. It is not sufficient to set up such a committee: it must be properly led by a person of standing who is also an enthusiast for improvements, and be assured of the support it needs to make its work effective. We are confident that if district Maternity Services Liaison Committees achieve the consensus that has been realised between the different groups on the Maternity Services Advisory Committee, the quality of antenatal care locally is bound to benefit.

6.3 Health authorities will need to keep their service under continual review. Any changes introduced in the light of the report should be evaluated at intervals to assess their effectiveness in providing an antenatal service more acceptable to its users.

6.4 Near the start of this guide we stated that the aim of antenatal care was "to ensure as far as possible the health and well-being of the woman and the unborn child." We are confident that if the action we have recommended is pursued by all concerned with vigour and enthusiasm there will be a new momentum in the improving trends in our antenatal services and that this aim will be increasingly realised.

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MATERNITY CARE IN ACTION

PART II: CARE DURING CHILDBIRTH (Intrapartum Care)

A guide to good practice and a plan for action

Second report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales

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FOREWORD

BY THE CHAIRMAN

This report follows on the Committee's first report on Antenatal Care published in September 1982. It covers the mother's care up to the completion of birth (intrapartum care) and stops short at this point. As childbirth and postnatal care are a continuous process, this may seem to some an abrupt and unrealistic point at which to end. It was chosen by the Committee to enable the section on intrapartum care, in which there is considerable interest, to be published without delay and to provide adequate time for the Committee's consideration of postnatal and neonatal care which will be the subject of a further report.

As a Guide to Good Practice and a Plan for Action the report takes the same form as its predecessor on Antenatal Care. By studying the report and applying the checklists, every Health Authority should be able to raise standards in their maternity service even though resource is limited.

The work of the Committee has been conducted in the firm conviction – much strengthened in the course of our proceedings – that the present practice whereby practically all mothers have their babies in hospital should continue to be promoted in the interests of the safety and welfare of the mother and her baby. The Committee recognised that there will be a few women who will choose to have their babies at home and their needs are covered in a separate chapter of the report.

The practice of delivering nearly all babies in hospital has contributed to the dramatic reduction in stillbirths and neonatal deaths and to the avoidance of many child handicaps. But the rapid development of new equipment and techniques now available in hospitals has brought with it many problems both for the professions and for the users of the service, resulting in much questioning and public debate on the quality of care provided.

Consequently in recent years there have been many guides to good practice published by the professions and other interests. What makes the work of this Committee unique and authoritative is that it combines the views of all the professions with the views of users. While the Committee recognise that most members of the professions maintain high clinical standards, there is undoubtedly justification for the dissatisfaction with the service now being strongly expressed by a number of users and those who represent them. Much of the work of the Committee has, therefore, been directed to seeing how the level of satisfaction can be raised without detriment to the level of medical and midwifery care now provided and in particular how communication between the professions and the users can be improved.

Maternity care is exceptional in the Health Service insofar as the large majority of those for whom the care is provided are healthy women who come into hospital not to be treated or cured like a patient but to be assisted in a natural physiological process which for most of them is among the most important events in their lives. This requires a somewhat different approach from staff and a recognition that

where complaint does arise it is often well articulated, often well supported and calls for a well considered response.

Childbirth can give rise to intense emotion and to a whole range of problems for the mother and her family. The need for understanding of her feelings and support for the mother in her social circumstances can often be just as important to a safe and satisfactory birth as physical care. These needs require time and thought and a high level of communication between staff and users at every stage if trust between the providers and the users of the service is to be established and satisfaction achieved.

In addition, we found organisational weaknesses in the service. Much more needs to be done within hospitals to develop agreed written operational policies which are clearly defined and are understood by all the professionals concerned. Without these, confusion over who does what and when can and does result.

We saw it as no part of our role to lay down professional standards of training and care. But as a Committee representing all the professions concerned with maternity care and including lay representatives, we were in a strong position to examine together how the professions relate to each other, how current practice could be improved, how a better use could be made of available skills and, above all, how lay opinion should be accommodated to the greater satisfaction of all concerned. The Committee is much indebted to the consultant representatives for the manner in which they have been ready and willing to lay their professional practice "on the line" and to respond to criticisms and suggestions that come from other members of the Committee.

We were asked by the Minister to consider how Health Authorities should be advised on standards for staffing and equipment in the delivery suite. There are a few standards which we are agreed are an irreducible minimum. They include the immediate availability of a doctor for the delivery suite without other conflicting commitments and the need in each shift for a midwife to have personal responsibility for each mother even though in the early stages of labour she may not have to be with her all the time. These standards of staffing and equipment recommended should apply in every district's maternity service, irrespective of local conditions. The standard for other aspects of the service will depend very much on local conditions, such as the accessibility of communities to a consultant maternity unit and medical and nursing establishments. With the widespread variations in local circumstances it would not be realistic to set national minimum standards for a wide range of staffing and equipment, particularly if they required Authorities to switch large amounts of resource to the maternity service ahead of the needs of other priority care groups.

This is not to say that there will not be many instances where a study of local services will reveal deficiencies that should be remedied. There is in the Health Service a need for more information to support all bids for additional resource and in future such bids are likely to be based less on "norms" or minimum standards, which can on occasion prove unrealistic, than on a much wider examination of the whole spectrum of current practice and on comparison with comparable units both within the region and nationally. Examination of our

checklists should provide much information that will help Authorities to evaluate the service they provide, answer public criticism, and assess the priority that should be accorded to remedying deficiencies. It should also enable them to check whether their resource is being used as effectively as possible.

The final chapter stresses the role of local Maternity Services Liaison Committees – which have yet to be established in all Districts – and what they can do to get professions to work more closely together to evaluate their service, raise standards and monitor progress.

I feel personally indebted to all members of the Committee who have given much thought and time to our debate and to the drafting of the report. I have greatly valued their awareness throughout of the need to reach consensus on the basic elements of good practice. It is this consensus that gives strength to the report and does, I believe, set an example which local Maternity Services Liaison Committees should seek to follow.

Although we have suffered several changes in the secretariat, all made a contribution to our work. I am indebted to them and particularly to the most recent appointments who have brought this report together and to other Departmental officers who have helped me throughout.

ALISON MUNRO

CHAPTER 1: INTRODUCTION

1.1 This report on "Care during Childbirth" (Intrapartum care) is the second of the Committee's reports. The first report, published in September 1982, dealt with antenatal care. This one ends with the birth of the baby and there will be a further report on the care of the mother and her baby after the birth.

1.2 Like the report on antenatal care, this report presents a guide to good practice with checklists which the professions concerned with care during childbirth, users of the service, Health Authorities and lay interests can use either individually or collectively, to check current practice and take appropriate action to ensure that standards of care are the best that can be provided.

1.3 The report lays considerable emphasis on the importance of the preparation of the mother and father, and indeed the whole family, for the experience of childbirth but does not repeat the content of the first report on antenatal care. It supplements that report however, by emphasising those aspects of antenatal preparation that are particularly important if the birth of the baby is to be as safe and as emotionally satisfying as possible.

1.4 Chapters 2 to 4 set out general principles which apply to the care of all mothers admitted to hospital for the birth of their baby. For the large majority of these, childbirth will be uncomplicated. The next two chapters deal with the care of mothers when complications arise either during pregnancy, when antenatal admission to hospital may be necessary, or during labour. Although the Committee expect that the number of women having their babies at home will continue to be very small, they felt the subject of planned home births was important to professionals, mothers and their families and merited a chapter on its own.

1.5 There is also a chapter on those aspects of the layout and equipment of the delivery suite which the Committee regards as basically essential to good practice.

1.6 The report ends with a chapter giving further advice on the role of the Maternity Services Liaison Committee. This is intended to help Health Authorities set up such Committees where they do not already exist and to enable them to develop their service on the basis of this report with full regard to local circumstances.

1.7 References are made throughout the report to the role of the baby's father. It is assumed that in the absence of the father, a close relative or friend might be present instead, and sometimes also a companion to translate if the mother does not speak English.

CHAPTER 2: PREPARATION FOR CHILDBIRTH

Policy statement

2.1 The aim for everyone concerned with the birth of a child must be to ensure the safety and health of the mother and baby and to make the event a satisfying and happy experience for her, the father and the whole family.

2.2 The achievement of this aim will depend in a large measure on how the mother and father have been helped by the professions to prepare for the event during the antenatal period. This is the time when trust between the mother and all those involved in her care should have been established through explanation and discussion of the mother's expectations and of the maternity unit's operational policies. These policies should recognise the influence of emotional and social factors on the progress and the outcome of labour. Each mother should have been given the opportunity to familiarise herself with the unit's environment, which for many will be strange, and to have met the staff who are likely to care for her.

2.3 By the end of the preparation the mother should feel confident in the services available to her and her own competence to give birth to, and care for, her baby.

2.4 Staff must recognise that most mothers are healthy women for whom labour and birth are important physiological and emotional events. A mother is not necessarily a "patient" and should not normally be referred to as such.

Choice of maternity unit

2.5 Normally, after her initial assessment, a provisional booking will be made for the mother at a maternity unit. Sometimes she may find that the unit she has chosen does not offer the type of care she desires and alternative arrangements will need to be considered. The booking may have to be reconsidered with her at any time.

Preparation for labour and parenthood

2.6 As part of her antenatal preparation, each mother should be encouraged and helped to prepare for labour and delivery, and to care for her baby. She should be given opportunities for private discussions during clinics. Group classes should encourage discussion of procedures that may be followed during labour and the operational policies of the maternity units in which mothers are booked.

2.7 Appropriate organisations and volunteers should be encouraged to help women in their preparation for childbirth and motherhood, especially those

women with special cultural or other needs. They should work in partnership with maternity units to ensure a consistent approach.

2.8 Every mother should be encouraged to visit the maternity unit where she will be having her baby, to get to know the layout of the unit and to meet the staff. If she wishes, she should be able to discuss any special aspects of her care with the senior midwife. She should also be offered the opportunity of seeing the special care baby unit.

Individual interests and needs

2.9 Although not all mothers will wish to know in detail the processes involved in giving birth, many will. Each mother's interests and needs must be individually considered.

2.10 Every mother should have the opportunity to discuss and agree an individual plan for her care during labour and childbirth. Most will be content with the maternity unit's normal procedures if these are explained to them; but some will have particular preferences about aspects of their care, and these should be carefully recorded along with any advice given. The plan agreed during the antenatal period must be flexible as no labour or birth is completely free of the risk of complications, and medical advice or the mother's views might change.

2.11 Matters which are of particular concern to mothers and which might require discussion include:

—the role the father is to play during labour and delivery
—pain relief
—fetal monitoring
—the position the mother wishes to adopt during labour and delivery
—the mother's first contact with her baby
—procedures if complications arise
—feeding the baby.

Preparation for admission

2.12 Every mother should be told well in advance how to recognise the early symptoms and signs of labour and what she should do when they occur. She should have the telephone number of the maternity unit and written instructions, in a language she understands, on how to get there and on any special arrangements for night admissions.

2.13 Many mothers will need to make special domestic arrangements during the time they are in hospital and staff should help, where they can, to see that these are made in advance.

Regular review of arrangements

2.14 Maternity Services Liaison Committees should consider from time to time in the light of views of parents and staff whether antenatal care gives sufficient emphasis to the importance of developing procedures which help to establish trust and confidence between mothers and those who are to care for them in labour.

ACTION CHECKLIST A

PREPARATION FOR CHILDBIRTH

A.1 Is antenatal care organised in such a way that adequate time can be devoted to establishing a mother's confidence and trust in the staff and to alleviating any anxieties she may have?

A.2 Is there local professional agreement on the scope and content of preparation of parents for labour and childbirth and the care of their baby? Are the views of mothers and staff taken into account?

A.3 Are all arrangements for the preparation of parents understood by all the professionals involved in the provision of maternity care? Is information about these arrangements co-ordinated, circulated and updated regularly by the MSLC?

A.4 Is the uptake of antenatal care monitored, and are efforts made to identify the categories of parents who do not take part? Are the views of parents and staff taken into account when arrangements are reviewed?

A.5 Are pamphlets or other written information about the availability of group discussions and classes provided for mothers and fathers in language which they are likely to understand, and are all encouraged to attend?

A.6 Are voluntary and other organisations participating in the preparation of mothers encouraged to work in partnership with the unit to ensure a consistent approach?

A.7 Are efforts made to meet families' cultural or other special needs?

A.8 Are convenient arrangements made for parents to visit the maternity unit and to discuss care during labour with the staff? When necessary, are arrangements made for parents who find it difficult to attend during normal working hours?

A.9 Are plans and instructions concerning special aspects of management during labour recorded in the notes, and are the mother's views on the following aspects clearly and prominently included:

—the role of the father in labour and delivery
—pain relief
—fetal monitoring
—the position the mother wishes to adopt during labour and delivery
—first contact with the baby
—procedures followed by the unit should complications arise
—feeding the baby?

A.10 Does the Health Authority ensure that information is provided for GPs concerning booking policies, availability of beds and special facilities which may be needed or desired by the mother?

A.11 Is each mother given written instructions on how to recognise the early symptoms and signs of labour and how to get to the maternity unit? Are these instructions available in a language she understands?

A.12 Does the delivery suite have a direct telephone line that by-passes the hospital switchboard? Is there a suitably qualified member of staff available at all times to answer this telephone?

CHAPTER 3: ADMISSION IN LABOUR TO THE MATERNITY UNIT

Policy statement

3.1 In the maternity unit, staff should aim to create a welcoming and friendly atmosphere and be supportive and understanding towards all mothers from the time they arrive. No matter how well antenatal preparation has been organised, some mothers will arrive at the unit unprepared and anxious. Some will arrive unannounced and some will be well advanced in labour. All should be given personal attention and helped to make themselves as comfortable as possible. Fathers, or a close friend or relative, should be welcomed and encouraged to stay and support the mother throughout her labour. Unaccompanied mothers will need special support.

Reception at the maternity unit

3.2 If birth seems imminent, the mother and father will be taken immediately to the delivery suite. In other cases, reception formalities should be completed without delay so that the mother can be settled in quickly and comfortably. She should be shown where to put her clothes and other belongings, where the toilets and telephones are and other facilities she and the father may wish to use.

Review of the plan for care during labour and initial procedures

3.3 The mother should be introduced to the midwife responsible for her care as soon as possible. Her records should be immediately available so that the midwife can check with her that they are complete and up-to-date, and that her individual needs and special wishes have been recorded. The midwife should take the opportunity of discussing anything that may be worrying the mother. For a mother who arrives unannounced or for whom the unit does not have adequate records staff will have to allow extra time to obtain the necessary medical history and to agree a plan for her care. The unit's operational policies should allow for such situations.

3.4 A clinical examination to assess the stage of labour will be carried out once the mother is settled in. Shaving of the pubic area or the administration of an enema should not be routine procedures; they should only be carried out if medically advised and with the mother's agreement or at her request.

Family support

3.5 If the father is to be present during the labour and birth, the midwife should explain and advise on the role he might play. The father should not be asked to leave the room during examinations if he and the mother are content for him to stay.

Further introductions to staff

3.6 The mother should normally be looked after by one midwife during each shift, and shift arrangements should be explained. Doctors involved in her care should introduce themselves and she should know which consultant obstetrician has responsibility for her care. If the maternity unit is used for medical or midwifery teaching, the mother's agreement should be obtained before any students are allowed into her room or to participate in her care.

ACTION CHECKLIST B

ADMISSION IN LABOUR TO THE MATERNITY UNIT

B.1 Are entrances to the maternity unit and delivery suite clearly signposted?

B.2 Is there always someone immediately available to welcome mothers, their relatives and visitors arriving at the unit?

B.3 Are there clear instructions on how to deal with emergency admissions, urgent admissions of women well advanced in labour and women who are not booked at the unit?

B.4 Are mothers' records immediately available in the maternity unit when they are admitted in labour?

B.5 Has a personal record system, where the mother carries her own casenotes, been considered?

B.6 Is each mother allocated a midwife who will be responsible for her care throughout her duty shift? Are shift arrangements explained?

B.7 Are mothers and their visitors told where to find the sitting areas, toilets, telephones and visitors' refreshment facilities?

B.8 In a maternity unit used for teaching medical students or student midwives or nurses, is their role explained to each mother and her agreement obtained to their participation in her care?

B.9 Do the unit's operational policies make clear that enemas and pubic shaving are not routine procedures?

B.10 Do all medical and midwifery staff introduce themselves to the mother and father and wear name labels?

B.11 Is the presence of the father, or another companion, encouraged during labour and delivery? Is the father advised on how he can best support the mother?

CHAPTER 4: LABOUR AND BIRTH

Policy statement

4.1 The overriding objectives of everyone in the delivery suite are to ensure the well-being of the mother in labour and to help her give birth to a healthy baby. To this end, teamwork by the professionals and co-operation between the mother and those assisting her is essential. The mother will be greatly helped if the staff maintain a calm and unhurried atmosphere and if she feels there is consideration of her own personal needs and wishes. Such an approach will help her to relax, to feel in control of the process of giving birth, and to trust and be receptive to advice.

Clinical operational policies

4.2 In a consultant maternity unit, and to a lesser extent in a GP unit, the mother may be cared for by several members of staff of different disciplines. To ensure a consistent standard of care and avoid any confusion over practice each unit should have written operational policies which have been developed with all disciplines and which all staff understand.

4.3 In the consultant unit, these should be agreed by senior medical and midwifery staff. While not precluding variations in approach between different consultant teams in the same unit, these policies should make clear the procedures which will be followed by midwives, doctors and support staff both during an uncomplicated labour and if complications should arise. The senior staff of a unit should review written operational policies at regular intervals in the light of new knowledge and techniques, the results of perinatal audits and comments from parents and staff.

4.4 In GP maternity units, the operational policies agreed by the GPs and midwives, besides defining the responsibilities of GPs and midwives towards the mothers in labour, should cover how and when the doctor responsible for a particular mother should be called to attend, arrangements for the transfer of mothers to specialist care, how hospital support services can be called upon and how records should be maintained.

4.5 The Maternity Services Liaison Committee for a district has an important role to play in ensuring that unit policies exist and are kept under review.

Role of the midwife

4.6 Normally the midwife will be the key person supporting the mother. At the end of her shift she should hand over care to another midwife in the mother's presence. The senior midwife in overall charge should have a broad picture of the progress of all the mothers in labour, but decisions about the care of individual mothers should be taken by the midwife immediately responsible.

Medical cover

4.7 In every consultant unit there should be a doctor immediately available for the delivery suite, who should have no other conflicting commitments. A consultant obstetrician or his deputy should be available to take over from junior medical staff when necessary. An anaesthetist and a paediatrician should be available, ideally on site, to attend promptly when required to deal with unforseen emergencies. Obstetric and midwifery staff should be trained to resuscitate babies in emergencies, especially where there is no paediatrician on site. Future hospital planning in bringing obstetric and paediatric facilities together on the same District General Hospital site should ensure that a paediatrician and an anaesthetist will be available to attend at once.

4.8 A GP responsible for the care of a mother during labour should not have commitments which preclude attendance if called on.

Privacy

4.9 A mother should not be left alone but at the same time no-one should enter her room unnecessarily. If a midwife cannot be present with her continuously, the father, or student if one has been allocated to her, must know how to get immediate help.

Mobility and position during early labour

4.10 During early labour the mother should be free to adopt the position in which she feels most comfortable, consistent with her safety and that of her baby. She should be free to walk about unless there are overriding medical reasons for her to be in bed.

Monitoring

4.11 The midwife and doctor concerned need to know about the condition of the mother and baby and how labour is progressing. Methods vary from the use of a stethoscope to listen to the baby's heartbeat and feeling the mother's abdomen to assess the frequency and strength of her contractions, to the use of electronic apparatus.

4.12 Electronic monitoring does not replace personal care, but can be invaluable adjunct to it. It has the advantage of providing a continuous record and of correlating fetal heart rate and uterine contractions; this permits closer supervision, the early detection of irregularities, and prompt action when called for.

4.13 Some mothers dislike the idea of electronic monitoring, especially if it restricts their mobility or involves the artificial rupture of the membranes and the

attachment of an electrode to the baby's scalp. With adequate antenatal preparation and full explanation in labour of what is recommended, it should be possible to agree a method of monitoring acceptable to the mother and consistent with her safety and that of her baby. If the mother does not accept the form of monitoring recommended, this should be recorded in her notes and her wishes respected.

4.14 To be of value, the recordings from electronic monitoring need to be checked at regular intervals. Staff must understand the use of the apparatus,be competent to interpret and explain the tracings, and to discuss them with the mother and the father if required. All electronic equipment must be maintained in reliable condition, and back-up equipment should be available.

Relief of pain

4.15 Most mothers will expect and welcome some form of pain relief and will have discussed with staff during the antenatal period the types of analgesia available, how they are administered and their effects. The mother's progress during labour should be regularly reviewed and recorded to ensure that appropriate analgesia can be given at the right time. If the midwife or doctor believes some particular form of analgesia would be advisable, the mother should be given a full explanation of the reasons.

4.16 Mothers who do not wish to have any analgesics should be supported in this aim, but should be told that if they change their minds when in labour pain relief can be given.

4.17 Epidural analgesia can be provided only by doctors trained and experienced in its administration and in resuscitation. Not all units can.offer this. Doctors authorising midwives to top up epidurals should satisfy themselves that the midwives have had appropriate training.

Episiotomy

4.18 Episiotomy should not be performed routinely or without the mother's consent. However, perineal damage during delivery is common especially in mothers having their first baby. In many situations, for the benefit of the mother or her baby, doctors and midwives will advise episiotomy. The reasons should have been explained to the mother during her antenatal preparation and during labour if an episiotomy appears necessary.

Position during delivery

4.19 During delivery, the mother should adopt the position which she feels is most comfortable and effective, provided this allows the safe birth of her baby. The midwife or doctor attending her should endeavour to adapt to the position the mother wishes to take.

Delivery of the baby

4.20 The "crowning" of the head and subsequent delivery of the baby is an intense emotional experience for the mother and father. This moment is often accompanied by acute but short-lasting pain and the mother will need additional encouragement and support. She should be given the opportunity to see and hold the baby without delay, and to suckle the baby if she wishes.

Control and prevention of haemorrhage

4.21 The use of oxytocic drugs to aid the early expulsion of the placenta and reduce the loss of blood after birth is normal practice and it should have been explained during the antenatal period. It is beneficial and mothers should be encouraged to accept it.

4.22 It is also common practice to give all new born babies Vitamin K to prevent haemorrhage which is an uncommon but serious complication. The reasons for this should have been explained to the mother during the antenatal period.

4.23 In the rare event of a mother objecting to either of these measures, this should be recorded in the notes.

Suturing

4.24 An episiotomy or tear should always be sutured promptly, under a local anaesthetic if an epidural is not used. Staff in training should be allowed to do this only under the direct supervision of a doctor or midwife experienced in perineal suturing.

The parents with their baby

4.25 After a brief examination by the midwife or doctor, the baby should be dried and wrapped in a warm towel and offered to the mother and father to hold. They should be able to see the correct details written on their baby's identity bracelets and to confirm that these bracelets are put on their baby. They should then be given a period of privacy to share the experience of the new arrival in their family.

ACTION CHECKLIST C

LABOUR AND BIRTH

C.1 Does the maternity unit have written operational policies, agreed and updated at regular intervals by senior medical and midwifery staff, which make clear the roles and responsibilities of all members of the unit and how, when, and by which member of the team different procedures are to be carried out? Are all the staff aware of these operational policies, and notified when they are changed?

C.2 Are the views of parents, whether expressed individually or collectively, and of staff fully considered when the unit's policies are reviewed?

C.3 In each consultant unit, is there always a doctor with no other conflicting commitments immediately available for the delivery suite?

C.4 If an anaesthetist and a paediatrician are not available on site at all times, are obstetric and midwifery staff trained in resuscitative techniques?

C.5 For GP units, is it the practice that the doctor responsible for a particular mother's labour is available to attend her when required?

C.6 At the end of each duty shift, does the midwife hand over care to another midwife in the mother's presence? Are arrangements made to ensure that a mother is not left alone when her midwife is unable to be with her?

C.7 Are mothers free to move around and take up different positions during labour when there is no apparent risk to the mother and her baby? Are staff trained and willing to discuss with the mother the advantages and disadvantages of different positions for the delivery of the baby?

C.8 Is there always discussion with the mother about the type of monitoring in use in the unit which she may need and are her preferences respected?

C.9 Are all midwives trained to use the electronic monitoring equipment available in the unit and to recognise any deviations from normal recordings?

C.10 Do staff explain to the mother and father the recordings from electronic monitoring equipment and respond to any observations the parents may make?

C.11 Are there facilities in the hospital for maintaining electronic monitoring equipment in proper working order?

C.12 Are the selection and timing of appropriate analgesics agreed with the mother?

C.13 Are episiotomies performed only with the mother's agreement? Are the reasons for episiotomies explained to mothers both during the antenatal period and during labour if one appears necessary? Are episiotomies and tears sutured promptly?

C.14 Are the reasons for using oxytocic drugs and for giving Vitamin K to the baby explained to the mother?

C.15 Do staff ensure that the mother is given the opportunity to hold her baby without delay and to suckle the baby if she wishes?

C.16 Are parents able to see the baby given a preliminary examination and correctly marked identity bracelets attached? Are they then given the opportunity to be alone with their baby for a while?

CHAPTER 5: COMPLICATIONS DURING PREGNANCY AND ANTENATAL ADMISSIONS

Policy statement

5.1 Complications during pregnancy, especially if they require antenatal admission to hospital, can be particularly stressful for a mother and her family. The doctor and midwife should take time to discuss with the mother the nature of the problem and try to alleviate her anxieties. In recommending a type of care they should consider her basic needs as a pregnant woman as well as the condition that calls for special treatment. For some women, a period of close supervision at home might be an appropriate and preferable alternative to a stay in hospital.

The accommodation of mothers requiring antenatal admission

5.2 A mother admitted to hospital with antenatal complications should be looked after apart from any women admitted for the termination of their pregnancy.

5.3 A mother admitted in the later stages of pregnancy for a medical or surgical condition should generally be cared for in the maternity unit where her needs as a pregnant woman can be met unless there are overriding medical priorities which prevent this.

5.4 If it is foreseen that her newborn baby will need intensive care, the mother should ideally be admitted or, if necessary, transferred before the birth to an appropriate hospital. Such antenatal admissions might entail a prolonged hospital stay for the mother.

5.5 Mothers who are likely to be in hospital for a long time should be accommodated apart from mothers admitted in an emergency or for a short antenatal stay.

Arrangements for hospital stay

5.6 A mother's worries about the consequences of her admission to hospital will be aggravated if she has not had time to make prior domestic arrangements. Staff should discuss with each mother any concerns she may have and how they may best be resolved.

5.7 For a mother likely to stay in hospital for any length of time special care must be taken to ensure that her antenatal preparation is provided for.

5.8 Antenatal wards should provide an appropriate environment for mothers who can and wish to be up and about as well as those who wish or need to stay in bed. A day room and some recreational facilities must be provided.

5.9 Smoking should be discouraged and should be restricted to one area. Group or individual support should be offered to women trying to cut down or give up smoking.

5.10 The hospital's routine should not impose unnecessary restrictions. Mothers, who will mostly have been admitted for rest, should not be woken unnecessarily, particularly early in the morning. Their individual and special nutritional needs should be catered for.

5.11 Visiting should be arranged at any time within reason, and children should be welcome. Provision should be made for private conversations. Overnight accommodation for relatives may sometimes be required.

Going home

5.12 Before the mother goes home after an antenatal stay in hospital staff should make sure that her home is ready for her, liaising with community services as necessary. The mother's GP and midwife should be informed and normally consulted in advance. She should have an appointment for her readmission if necessary or for her next antenatal clinic visit. She should be told when the results of tests or investigations will be available and should be informed of their findings and significance as soon as possible.

ACTION CHECKLIST D

COMPLICATIONS DURING PREGNANCY AND ANTENATAL ADMISSIONS

D.1 When a mother has to be admitted to hospital during pregnancy does the doctor or midwife explain the nature of the problem in a way she understands?

D.2 Are community services adequate to provide antenatal supervision of mothers at home, when appropriate, as an alternative to hospital admission?

D.3 Are mothers who are admitted to hospital antenatally given all possible help in resolving any domestic problems created by their stay in hospital?

D.4 If special facilities for the care of the mother or baby are likely to be required, is the mother admitted to a unit where these are readily available?

D.5 Is there agreement between senior medical and midwifery staff on the most appropriate place and type of care for mothers admitted with different conditions and at different stages of pregnancy?

D.6 Are women who have been admitted antenatally cared for apart from women admitted for termination of pregnancy?

D.7 Does the organisation of the unit or hospital ensure that the care provided in the antenatal wards meets the special needs of pregnant women? For example by providing:

— facilities for those who can and wish to be up and about, as well as for those who wish or need to be in bed
— attractive adequate meals served at suitable intervals and facilities for making snacks
— protection of non-smokers from tobacco smoke, and help for those who want to give up smoking.

D.8 Are visiting periods flexible? Are visits by children welcomed?

D.9 Is special consideration given by medical and ward staff to the needs of mothers who have to stay in hospital for a long time? For example:

— ensuring adequate antenatal preparation
— allowing them, if appropriate, to go home for short periods, especially weekends, with detailed advice about how active they should be
— providing diversional and recreational activities and somewhere to sit out of doors.

D.10 When a mother is to go home are her GP and midwife informed in advance?

D.11 Does the doctor or midwife ensure that a mother leaving hospital:

— is given up-to-date information regarding her condition
— has an appointment for her re-admission or for her next antenatal clinic visit
— is told the results and significance of tests and investigations as soon as possible?

CHAPTER 6: COMPLICATIONS DURING LABOUR AND BIRTH

Policy statement

6.1 No labour or birth can be completely free of the risk of complications. Most mothers will know this and understand that special measures may need to be taken.

6.2 Every maternity unit's operational policies should include clear guidelines on the role midwives, doctors and other staff will play in dealing with foreseeable complications; emergencies arising in a previously normal case; emergency admissions; and the immediate care of low birthweight and ill babies.

6.3 When complications occur full records of events and action taken should be made as soon as practicable, and the personnel involved should be identified.

Foreseeable complications in childbirth

6.4 If problems are foreseen the mother should be booked and admitted into a consultant unit where appropriate anaesthetic, paediatric and other support services are available. When special services are required, the relevant hospital departments and personnel should be forewarned. Preparation in the antenatal period should give the mother a good understanding of her condition and of the procedures which may need to be advised.

6.5 In all such cases, the condition of the mother and baby will need to be closely monitored. The mother and father should understand the methods of observation used and the need for them, and should be aware that measures may have to be taken at short notice. The father should, if he and the mother wish, be present whenever possible during the labour and delivery. Staff should explain to the mother and father what is happening and see that the father knows what he can do to provide support.

6.6 In cases where the baby, when delivered, is likely to be at risk, the paediatric staff should be introduced to the mother. The obstetrician and the paediatrician should discuss the future management of the pregnancy and the timing and method of the delivery. The neonatal unit should be informed if the baby is likely to need intensive care.

6.7 Elective Caesarean sections should be planned for a time when staffing levels are optimal in the delivery suite and operating theatre, when an anaesthetist and paediatrician are available to attend, and when laboratory and other support services can be provided.

Unforeseen complications

6.8 When unforeseen complications arise decisions will have to be made quickly and there may be little time to determine the best course of action for the mother

and baby. The midwife or doctor must know whom to call for immediate assistance and be able to get that help without leaving the mother unattended. Written information must be available about how and where paediatric, anaesthetic and laboratory services can be obtained in emergencies. This should be regularly updated and be easily accessible at all times. Whatever decision is made, every effort should be made by the doctor and the midwife to keep the mother and father fully informed. The supporting role the father can play should not be overlooked.

Induction of labour and operative procedures

6.9 There is considerable concern among some women about what they consider to be unnecessary interventions in childbirth resulting from the too frequent induction of labour and the use of other procedures. It is generally agreed now that interventions should be avoided unless there are clear medical indications to the contrary. When mothers know that this is the local policy, they will more readily accept advice from their midwife or doctor if intervention becomes desirable.

6.10 To assist clinicians in the assessment of their practice, Regional Health Authorities (and the Welsh Office as appropriate) should collect and collate up-to-date statistics on the incidence of complications and of obstetric procedures and their outcome together with the characteristics of the population served by units throughout the region. MSLCs should compare the incidence in their own unit(s) with comparable units and report to the District Health Authority.

Consent for operative procedures

6.11 Informed consent for an operative procedure is required in obstetrics as in other forms of medical practice. Such consent should be given for a specific procedure, and the past practice of obtaining general consent for a range of possible procedures in advance, either during antenatal care or when a woman is admitted, has no merit. Written consent for planned procedures such as elective Caesarean section presents no difficulty, but a problem arises when emergency measures are needed, and especially when the woman is already under the influence of some forms of drugs. In these circumstances obtaining written consent is inappropriate. Informed consent given orally will then be sufficient, but this understanding must be recorded, and the staff member who was involved should be identified in the notes.

Emergencies outside hospital

6.12 Emergencies can occur outside hospital regardless of where the mother is booked for delivery. Unless a specialist preliminary assessment is required, the aim should be to bring the mother as quickly as possible into a consultant unit where the necessary facilities are immediately available.

6.13 When, in the view of the midwife or doctor on the spot, the mother should not be moved, they should be able to obtain an expert opinion of the situation from an obstetrician by telephone or to request an emergency domiciliary visit.

6.14 All Health Authorities must ensure that they have satisfactory arrangements for an immediate response to any obstetric emergency occurring outside hospital. These must be clearly defined and understood by medical, midwifery and ambulance staff so that specialist staff and equipment reach the mother as quickly as possible.

6.15 Some Authorities provide through their ambulance service "flying squads" which involve the pick-up of staff from a maternity unit and may deplete the hospital service. Some Authorities make other arrangements. For example, a consultant may carry an "air call" receiver wherever he goes and an emergency pack in his car; when a call is received the consultant proceeds at once to the emergency.

6.16 It cannot be assumed that specialist obstetric services will be immediately available at all times to attend emergencies outside hospital. On occasions some consultant units may not have sufficient staff immediately available to leave the hospital to attend an emergency elsewhere. In such circumstances the midwife or GP on the spot should be able to obtain expert specialist advice by telephone on the immediate clinical management of the case.

6.17 All Health Authorities whether they provide for emergencies by a traditional flying squad or by other means must review and test their arrangements regularly to maintain them at a high point of efficiency.

6.18 In every emergency a full record of events should be kept by the midwife or doctor involved. This will be critical for a safe hand-over of care. The midwife or GP who has been caring for the mother before her transfer to a consultant unit should if possible accompany her into hospital.

6.19 Emergency care of the baby will be dealt with in the next report.

Stillbirths

6.20 The death of a baby before or during labour can cause great distress and a sense of failure not only to the parents but also to the staff. The attitude of the doctors and midwives will be crucial in helping the parents come to terms with their loss. The training of all staff should help them to respond to the parents' needs and to cope with their own feelings.

6.21 If it is known that a baby will be stillborn it is especially important for the father, or a relative or friend, to be with the mother to give support and share the experience. In these circumstances it will be for the senior midwife on duty to decide who is the most appropriate midwife to be in attendance.

6.22 Many parents will be helped by seeing or holding their baby. Since some will have had no previous experience of death they may need reassurance and should be given time and privacy in which to decide whether to do so. For some

ethnic groups it may be appropriate for other members of the family to see the baby. If the baby has a severe abnormality or is macerated, particular care in wrapping and presenting the baby to the mother will be needed. If possible a photograph should be taken of the baby.

6.23 Parents should be given the opportunity of spiritual help and counselling suited to their religion, and offered the help of any local support group. The Health Education Council's booklet "The Loss of Your Baby" should be available for professionals to give to them. Parents should also be given any information immediately available about the cause of the stillbirth. Staff should explain to them, and also provide written information on, procedures for post-mortem examinations, registering the birth and recording the name of a stillborn child and arrangements for burial or cremation.

6.24 The parents should be offered an appointment to see the consultant obstetrician at a later date for further discussion and counselling. The mother's GP, community midwife and health visitor should always be informed of the stillbirth before she leaves hospital.

6.25 The counselling and other care required following a stillbirth or neonatal death will be dealt with more fully in the next report.

ACTION CHECKLIST E

COMPLICATIONS DURING LABOUR AND BIRTH

E.1 Are all high risk pregnancies booked into an appropriate consultant unit?

E.2 Do senior medical and midwifery staff ensure that all staff are aware of the unit's operational policies for dealing with different types of complications in labour and birth? Are arrangements for transferring mothers and receiving emergency admissions clear and known to all concerned?

E.3 Are all staff aware of the importance of obtaining informed consent for operative procedures? Do the unit's operational policies cover procedures for obtaining consent?

E.4 Are operative procedures and other proposed interventions explained to the mothers and fathers in terms which they understand and in the detail they want?

E.5 Do all staff make full notes as soon as practicable of the nature of any complications and the action taken; and identify themselves in the case record?

E.6 Are there efficient call systems for a paediatrician, an anaesthetist and others providing services as well as for the obstetric staff?

E.7 Are elective Caesarean sections always timed to take place when all necessary facilities are available and staffing levels are optimal? Can the obstetric operating theatre be adequately staffed in emergencies without seriously depleting skilled staff in the delivery suite?

E.8 When the delivery is likely to be undertaken electively does the obstetrician discuss and agree with the paediatrician involved the timing and its management where appropriate? Are the parents, and if necessary close relatives, always informed in advance about plans for delivery?

E.9 Are plans and instructions concerning the management of the mother's labour recorded and are her wishes on certain aspects of her care clearly and prominently included?

E.10 Are up-to-date statistics on the incidence of complications and of obstetric procedures and their outcome collected for each unit in each district? Do Regional Health Authorities (and the Welsh Office as appropriate) collate and provide District Authorities with such information on all units in the region together with information on the characteristics of the population served?

E.11 Has the Health Authority ensured that satisfactory arrangements have been made and agreed with consultants, GPs and the Director of Midwifery Services, to provide specialist advice and help when an obstetric emergency arises outside hospital?

E.12 Are there clearly defined arrangements between the maternity unit and the ambulance service for emergency admission and transfers including any special arrangements for 'cross boundary' flows?

E.13 Are staff taught how to care for parents who have had a stillborn baby or early neonatal death?

E.14 Are there copies of the booklet "The Loss of Your Baby", available to be given to parents who have had a perinatal death? Are these parents told about the support offered by such groups as the Stillbirth and Neonatal Death Society (formerly the Stillbirth and Perinatal Death Association)?

E.15 Are parents who have had a stillborn baby given the opportunity of spiritual help and counselling?

E.16 Is written information available on the procedures for post-mortem examinations, registering the birth and recording the name of a stillborn child and arrangements for burial or cremation?

E.17 If a mother has a stillborn baby is her GP, community midwife and health visitor always informed before she leaves hospital?

CHAPTER 7: PLANNED HOME BIRTHS

Policy statement

7.1 As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are readily available. Some mothers might prefer to have their babies at home, despite the possible risks, feeling that these are outweighed by the benefits they perceive to themselves and their families. Doctors and midwives should discuss the reasons for each mother's preference, so that her final decision is an informed one.

7.2 Health Authorities have an obligation to see that a midwifery service is available for home births. They must ensure that the provision made is as safe as circumstances permit and that local demand and arrangements to meet it are kept under review.

Preparation for home births

7.3 Some mothers want a home birth because they feel that they will be more relaxed and in control at home or because they regard childbirth as a family event and do not want to be separated from their families. Some may feel the hospital atmosphere is impersonal and fear that the procedures followed could lead to undue intervention. Some fear the possibility of infection. A few mothers may have been upset by the care received during a previous hospital birth.

7.4 Staff should try to dispel any misunderstandings; but if the concerns expressed are justified, the maternity unit's staff should be aware of them and take corrective action whenever possible. To help them in their decision, mothers and fathers should be encouraged to visit the local maternity unit.

7.5 Short-stay schemes, involving an expected stay of only a few hours in hospital after the delivery, or DOMINO schemes, (DOMiciliary IN and Out), where the mother's midwife accompanies her to hospital to carry out the delivery and returns home with her a few hours after the birth, have been shown to be a satisfactory alternative for some mothers wanting a home birth. Authorities should endeavour to develop such schemes, and staff should explain them when a provisional booking is being made.

7.6 The midwife and GP should encourage the mother to have a consultant opinion if there seems to be any medical or obstetric reason for her not having her baby at home. In these circumstances doctors and midwives would feel it their duty to try and persuade the mother to change her mind but they must recognise that the final decision is hers.

7.7 The midwife should visit the mother's home to check what facilities are available, whether she is receiving antenatal care, and to advise on arrangements.

7.8 Every mother booked for a home delivery should have the telephone numbers of her GP and midwife, and know how to contact them when help is needed.

7.9 A booking for a home delivery, like any other delivery will need to be kept under review.

Medical and midwifery cover

7.10 Although the demand for home births varies and will usually be small, Health Authorities should ensure that there are policies agreed between the professions to provide mothers who choose to have their babies at home with adequate antenatal, intrapartum and postnatal care and that these arrangements are well known locally.

7.11 While many GPs are willing to provide antenatal and postnatal care, not all will be trained or willing to provide care during labour. Family Practitioner Committees should compile, maintain and make available an up-to-date list of GPs who are willing to provide complete maternity services and whom mothers can contact. Where a midwife anticipates difficulty in obtaining medical cover for a particular case she should report this to her Supervisor of Midwives, who should ensure that appropriate local arrangements are made so that medical advice will be provided.

7.12 Every district should have midwives available to attend home births who undertake a sufficient number of deliveries each year to maintain their confidence and skills.

7.13 During a home birth, the midwife should be assisted by another responsible person. The GP should be available throughout the labour, but will not normally be present all the time. The midwife and GP must be prepared to meet the mother's reasonable wishes for the delivery.

7.14 Health Authorities must provide midwives attending a home birth with the necessary equipment including that for analgesia, resuscitation and suturing. Midwives who work in the community need some form of 2-way emergency call system.

Dealing with emergencies

7.15 If an emergency arises, the midwife must call medical assistance. Normally this should be the GP responsible for the mother's care in labour. If he cannot be contacted or if no such arrangements exist, midwives should know that in an emergency they can call any GP who will be bound to attend. The emergency arrangements for obtaining the assistance of hospital staff outlined in Chapter 6 apply as much to a planned home birth as to any other obstetric emergency arising outside hospital.

Regular review of arrangements

7.16 Maternity Services Liaison Committees should keep local arrangements for dealing with home births under review, and the Director of Midwifery Services should make an annual report to the MSLC on the service provided.

ACTION CHECKLIST F

PLANNED HOME BIRTHS

F.1 Is the District Health Authority satisfied that it provides a service for planned home births which offers maximum safety for the mother and baby within the constraints of the facilities and resources available? Is the level of demand for home deliveries kept under review?

F.2 When a mother wishes to have her baby at home, do the midwife and GP discuss with her the reasons for her preference; and is she encouraged to seek a consultant opinion if there seems to be any medical or obstetric reason for her not having her baby at home?

F.3 Are "short-stay" and "DOMINO" deliveries provided and recommended as alternatives to a home birth? If not, are they being considered?

F.4 If a mother wishes to have her baby at home, are there clear guidelines which would enable the GP and midwife to confirm that it is appropriate for her to do so? Conversely, are there criteria by which they can identify those high risk mothers whom they should strongly advise to have their baby in hospital?

F.5 Does the Family Practitioner Committee make available on request a list of GPs who may be willing to provide complete maternity services for a planned home birth?

F.6 Is there an agreed procedure for the Supervisor of Midwives to ensure medical advice is provided when this cannot be obtained from the mother's GP?

F.7 Do GPs who are willing to undertake home deliveries make arrangements for 24 hour cover?

F.8 Are midwives aware of the services available to deal with emergencies arising during home births? Are the adequacy and efficiency of these reviewed by the MSLC at regular intervals? Are midwives working in the community provided with some form of 2-way communication system?

F.9 Are the arrangements that may have to be made in an emergency explained and discussed with the mother?

F.10 Are midwives who attend a home birth provided with the necessary equipment including that for analgesia, resuscitation and suturing?

CHAPTER 8: DELIVERY SUITE DESIGN AND EQUIPMENT

Introduction

8.1 The Department of Health is at present revising its Maternity Department Building Note. The following design features and equipment should be included in any new delivery suite and, as far as practicable, in any upgrading of existing buildings.

Siting of the maternity unit

8.2 The consultant maternity unit should be part of the main District General Hospital and sited so that the facilities and services of the Departments of Anaesthetics, Paediatrics, Pathology, Radiology and Pharmacy are readily available. The delivery suite should be close to the antenatal wards and facilities for the care of the newborn.

8.3 Ideally GP maternity facilities should be integral or adjacent to consultant units. In some localities, however, geographic factors will require the continued availability of GP units distant from the consultant unit.

General environment

8.4 Although it is staff attitudes more than anything that create a reassuring and welcoming atmosphere, a reception area and delivery room which look unclinical will help to provide a friendly and relaxed environment. Much can be done at low cost by the use of wallpaper, curtains and other soft furnishings.

Delivery rooms

8.5 To avoid the need to move a mother when her labour is well advanced, all procedures for her admission, labour and delivery should be carried out in the same room. Each delivery room should be reasonably sound-proof and should afford the mother and father some privacy. All rooms should be draught-free and the temperature should be quickly adjustable.

8.6 Delivery rooms should be large enough to allow for flexibility in the type of delivery, to accommodate an adjustable bed and at least one easy chair and to provide space for the mother and father and the staff to move around. They should be suitable for all types of vaginal delivery; where this is not practicable, a larger room for abnormal deliveries will be needed. One delivery room may need to be designed and equipped to be suitable for mothers who require intensive care before or after delivery and who could be there for several days.

8.7 The delivery room should have windows and artificial lighting should be adjustable in intensity and in focus. Additional lighting must be available for clinical purposes. Technical and emergency equipment for mothers and babies though immediately available should preferably be stored out of the room if space allows or in wall cupboards in the delivery room which may be serviced from adjacent corridors. Each room must have a "surgeon's" basin and ready access to toilets and showers suitable for pregnant women.

Sitting room area

8.8 There should be a general sitting room area for mothers and visitors within the delivery suite with access to toilets and telephones and refreshment facilities. Smoking should be discouraged but if space and resources permit there should be an additional separate sitting room for smokers. Sitting rooms should have windows.

Operating theatre

8.9 An operating theatre suite of adequate size, for the sole use of the maternity unit, should be an integral part of the delivery suite. Because specialist equipment may be needed quickly and in view of the nature of its workload, the theatre should have stand-by sterilising facilities. Piped oxygen, nitrous oxide and suction should be standard equipment for the care of both mother and baby. Gas scavenging facilities should be available.

8.10 A separate anaesthetic room should be provided but in some units it may be practicable, or desirable, to induce anaesthesia in the delivery room or the theatre itself.

Recovery area

8.11 A recovery area is needed near to the theatre where staff can monitor closely the condition of mothers recovering from a Caesarean section or other complicated birth, and from the effects of anaesthesia.

Storage and utility

8.12 Within the delivery suite, adequate storage space should be provided for large items of equipment and furniture as well as for linen, disposables, sterile supplies, drugs and surgical stores. There must be suitable facilities for the storage of blood for immediate use.

8.13 Dirty utility and waste disposal facilities must be central yet out of sight and accessible for collection.

Medical gases, suction and electricity supply

8.14 Every delivery room and the recovery room should have piped medical gases and suction for the mother and baby. The delivery suite should be connected to an emergency generator to ensure an uninterrupted electricity supply to essential equipment. There should be sufficient electrical sockets for x-ray and other portable equipment.

Staff facilities

8.15 In every delivery suite there should be toilets and changing facilities for staff, and a sitting room reserved for their use during breaks. Over-night accommodation for obstetricians, paediatricians and anaesthetists on call should be provided in the maternity unit or close by on the hospital site so that staff can be immediately available. A room in the delivery suite should be available for the instruction of junior doctors, nurses and midwives in training and medical students.

Refreshments

8.16 Facilities for preparing light refreshments should be provided in the delivery suite, for use when other facilities are not readily available.

Equipment for the delivery suite

8.17 The following equipment or apparatus should be available in every delivery suite:

- apparatus for electronic fetal monitoring
- apparatus for inhalation analgesia
- equipment for the resuscitation of the newborn and for maintaining the baby's body temperature
- a transport incubator
- apparatus for general anaesthesia
- facilities to assess pH and blood gases
- equipment for monitoring and resuscitation of the mother, including equipment to deal with cardiac arrest.
- a portable ultra-sonic scanner
- infusion pumps.

All the equipment should be serviced and checked regularly, and procedures for this should be covered in the unit's operational policies. Facilities should be available within the hospital for equipment to be repaired and maintained.

8.18 Delivery beds should be designed primarily for the mother's safety and comfort, and be capable of adapting to different positions for the mother to give

birth. Birth chairs and stools, padded ledges and other such aids should be available for mothers who want them.

8.19 Isolated GP units should be equipped to a standard to cope with the complications that may have to be dealt with on site.

CHAPTER 9: MATERNITY SERVICES LIAISON COMMITTEES

9.1 In concluding their first report, on antenatal care, the Maternity Services Advisory Committee strongly recommended that every District Health Authority should establish and maintain a Maternity Services Liaison Committee to help implement, in the light of local circumstances, the Committee's advice on good practice and plan for action.

9.2 A Maternity Services Liaison Committee should act as a multi-disciplinary forum, reaching agreement between the different professions and drawing on the experience of the users. The following list of functions, which are not exclusive, is offered as an indication of the role of MSLCs, to help Health Authorities to set up Committees and to ensure that they work efficiently:

i. to ensure that the best possible standard of maternity care is available for all mothers;

ii. to ensure the best use of professional skills and resources;

iii. to consider how, in the light of local circumstances and available resources, current practice might be improved by taking action in accordance with the reports of the Maternity Services Advisory Committee;

iv. to agree procedures which ensure good communications, especially in those areas which involve both hospital and community staff, particularly arrangements for shared care, admissions and discharges and emergencies arising outside the hospital;

v. to promote agreement on the respective roles of the different professional groups and to ensure that there are agreed operational policies and procedures and that these are kept under review;

vi. to promote the recognition and use of GPs' and midwives' skills and those of other members of the primary health care team, enabling them to provide mothers whose pregnancies are regarded as "low risk" with more of their antenatal care in the community, reducing both the inconvenience of travelling for the mother and the load on the hospital service;

vii. to encourage the provision and utilisation of facilities for GPs and midwives to update their skills and knowledge of developments in obstetric practice;

viii. to give consideration to parents' views as expressed individually and collectively;

ix. to advise on the development of a record system which avoids duplication between the professions and ensures that mothers' records are immediately available when required;

x. to keep under regular review the performance of the District's maternity services, in the light of statistics on perinatal deaths and on the incidence of complications and of obstetric procedures;

xi. to encourage the setting up of a Perinatal Confidential Enquiry (where such an Enquiry does not already exist) to review perinatal mortality and morbidity throughout the District, and to promote co-operation in the Enquiry and review the collated reports;

xii. to encourage the prompt reporting of maternal deaths to the District Medical Officer (or Chief Administrative Medical Officer in Wales) for the Confidential Enquiry into Maternal Deaths;

xiii. to report regularly to their District Health Authority, and receive reports from the Authority on their proposed action in response to the MSLC's recommendations.

9.3 Each Committee should represent all the professions, to ensure integration between the hospital and community services and between the different professions. It should be led by a person of standing who has the enthusiasm and time to make it work effectively. It may well be that a Committee will wish to meet in two forms: as a professional group when clinical and confidential matters or individual cases are to be discussed and with a wider membership including lay people who are users or representatives of users of the service for all other purposes.

9.4 While Maternity Services Liaison Committees have an important advisory role, it is Health Authorities which have the responsibility for ensuring the provision of adequate maternity services. Health Authorities must keep their services under continual review.

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MATERNITY CARE IN ACTION

PART III: CARE OF THE MOTHER AND BABY (Postnatal and Neonatal Care)

A guide to good practice and a plan for action

Third report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales

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FOREWORD

BY THE CHAIRMAN

This is the third report of the Maternity Services Advisory Committee. It covers the care of the mother from the time of her baby's birth to the completion of her postnatal care and the care of her baby in the first weeks of his life.

The report takes the same form as the previous two reports on Antenatal Care and Care during Childbirth, providing a guide to good practice and checklists which are designed to aid professionals and users to review current practice and raise standards of care. The Committee co-opted for this part of their work to its already strong membership two additional Consultant Paediatricians, a Consultant Psychiatrist and an Assistant Director of Social Services. By combining the views of their fully representative membership, the Committee felt they were, as before, in a unique position to give authoritative advice, which has the strength of being commended by leaders of the professions, of being acceptable to users and, in terms of the resource available to the health service, of being realistic and achievable.

For the mother, her postnatal care is as important as the birth itself. Unfortunately in many maternity units it has had the lowest priority, and the mother's joy and satisfaction in the birth of her baby is marred by inadequate and underqualified care, by confusing and conflicting advice and by poor communication between the hospital and the community staff who will care for her and her baby at at home.

Parents of newborn babies are particularly vulnerable to conflicting advice both from the professional staff attending the mother, from family and friends who have their own perception of satisfactory care and from lay organisations who produce many booklets and other advice. This places an obligation on the doctors and midwives and other professional staff working as a team to produce operational policies which are well understood by those attending the mother both in hospital and in the community and which ensure that she receives consistent advice throughout.

We have identified a paramount need in the postnatal period for babies to be cared for alongside their mothers unless there are overriding medical or social reasons that require them to be separated. This is already recognised as good practice, and increasingly much of what has come to be known as "special baby care" takes place alongside the mothers in the postnatal area. This practice is likely to increase as staffing levels improve. The term "Special Care Baby Unit" which suggests a concentration of special care in one place is no longer apt. We should like to see it phased out and replaced by the term "Neonatal Unit" to describe the unit giving such special baby care as cannot be provided in the postnatal area, as well as intensive neonatal care. The amount of intensive care provided will vary between units but even the smallest consultant unit must be expected to provide a measure of intensive care to sustain the baby at least until he can be transferred elsewhere.

In our previous reports we placed considerable emphasis on the 'consumer' aspects of antenatal care and childbirth and much of the good practice recommended aims

at overcoming the dissatisfaction which many mothers have expressed about these aspects of their maternity care. We also stressed the need for operational policies in hospitals discussed and agreed with the professionals concerned as a basis for good practice and for ensuring a better use of the skills available.

In our study of postnatal care "consumers" and professionals were equally aware of certain areas where standards clearly need to be raised. Both acknowledge the need to provide better support for parents who suffer a stillbirth, or the death of their baby or whose baby is born with a severely handicapping condition. It was also clear that professionals are far from satisfied with the standard of care they are able to provide for very small or ill babies requiring long term intensive care. Many designated Regional Centres are working under considerable strain with facilities which, in their view, are totally inadequate to meet the rising demand created by the prospects of survival of more very small and ill babies. Many District General Hospitals are already providing a measure of neonatal intensive care from their own resources but the provision is often unplanned and haphazard and insufficient to meet changing need.

The consultant paediatricians on our Committee felt strongly that to meet this situation there was a need for the Committee to state the minimum number of cots which must be provided in each Region for every thousand births. While fully endorsing the reasons for the consultants' concern, we have been reluctant to be specific about the number of cots to be provided bearing in mind that "Norms" by their nature cannot realistically take account of available resource or local variation. We are concerned to see action taken throughout the service to remedy the deficiency in a practical and realistic way. We have therefore laid the responsibility on each Region to assess its overall need in the light of regional circumstances and to determine a 10 year strategy which will build on the existing provision and take account of the possibility that some Districts which can develop the necessary skills and resources will care for their own small or ill babies. This we see as desirable, particularly in maintaining family links. However, we see a strong need for each Region to designate one or more Regional Perinatal Centres setting standards of training and undertaking research into the care of the newborn and caring for the increasing number of very small or seriously ill babies who require intensive care over a long period.

We recognise that the commitment of Regions to the strategic objectives outlined will involve some redistribution of the total resource available for neonatal care, which in some and possibly all Regions may have to be increased if acceptable standards of neonatal care are to be achieved. The amount involved and the level of distribution will depend on each Region's assessment of relative priorities and the timing of change, and should have regard to the latest advice available from professional organisations. We believe that no real progress will be made until each Region has a strategy which first assesses need in terms of the incidence and distribution of low birthweight babies, and which, having examined how existing resource is being used, plans with its Districts the pattern of care to be developed and also designates the amount of long term intensive care that will need to be provided at Regional Perinatal Centres. Those Regions which do not have such a strategy should develop one as a matter of urgency and ensure it begins to take effect without delay.

Once again we highlight the need for and importance of the Districts' Maternity Services Liaison Committees as the principal instrument in the district for reviewing standards of service, and for using the checklists as a basis for recommending any improvements necessary. The checklists are intended to provide for regular reviews and, if they are to be fully effective, must be considered in depth in conjunction with the text and revised from time to time to take account of developments in clinical practice and in user interests. A Maternity Services Liaison Committee which uses the checklists as a "one off exercise" requiring only the briefest of answers is failing the service and all who use it. Health Authorities have a responsibility to see that these Committees work regularly and effectively and are properly supported.

I am again indebted to the Department's advisers who have supported me throughout our work with sound advice and help. This has been the most difficult part of our work, covering much new ground where the lines of good practice were less easy to identify and formulate. The Committee is particularly grateful to Michael Brown and his assistant, Anne Thyer, for the untiring way in which they have sought and coordinated members' views and for their work on the drafting of the report.

Finally, I should personally like to thank the members themselves for the goodwill and constructive effort they have put into our task. We have had our arguments and disagreements but each member has recognised the need for a consensus on all the complex issues discussed, acknowledging that a small sacrifice of an individual viewpoint is more than compensated for by the strength of the united view expressed and the promise which the reports of this Committee should provide of a high level of maternity and neonatal services throughout England and Wales.

ALISON MUNRO

CHAPTER 1: INTRODUCTION

1.1 This is the third guide to good practice issued by the Maternity Services Advisory Committee. The Committee's first report, published in September 1982, dealt with antenatal care; the second, published in January 1984, with childbirth and ended with the birth of the baby. This report covers the postnatal care of the mother and the care of her newborn baby.

1.2 The format is the same as for the previous two reports. Each chapter on good practice is backed by a checklist to be used by those who provide and those who use the services. By going conscientiously through the checklists in conjunction with the relevant chapters, Health Authorities, Maternity Services Liaison Committees, health and other professionals and lay people should be able to work together to raise standards of maternity care even in the best units and use the combined skills of professionals and the resources available to best advantage.

1.3 Chapter 2 sets out the general principles which apply to the care of mothers and babies when childbirth has taken place in hospital and both mother and baby are healthy. The next three chapters deal respectively with the care of mothers who have special needs, the care of small and ill babies, and the care of babies who have a congenital malformation or a risk of handicap.

1.4 Chapter 6 covers the care and support required by mothers and their babies at home, including those mothers who have had a planned home birth. Chapter 7 is devoted to the special needs of parents whose baby is stillborn or who dies shortly after birth. Chapter 8 offers advice to Health Authorities on the assessment of staffing needs for postnatal and neonatal care. There follows a chapter on essential features in the design of accommodation used for postnatal care and of the neonatal unit, and on equipment, which the Committee regards as basic to good practice.

1.5 The report refers back at various points to the antenatal preparation of the mother and father for the birth of their baby, because sound preparation is essential if aftercare is to be effectively provided. The final chapter points the way forward showing how the report and checklists should be used to attain continuing improvements in the service.

1.6 The general principles of postnatal care, which the report outlines, apply whether the baby is born in a consultant maternity unit or in GP hospital facilities, and apply also to mothers who plan to and have their babies at home.

1.7 Reference is made throughout to the involvement of the father in supporting the mother and in the care of their baby. When the father is not available to provide that support the same reference applies to any close relative or friend whom the mother chooses to have with her.

1.8 As no regional tier of the NHS exists in Wales, functions fulfilled in England by Regional Health Authorities are in Wales undertaken by the Welsh Office or devolved to District Health Authorities. References throughout the report to regional policies or authorities should be interpreted accordingly.

1.9 As in the Committee's previous reports, references are made to the baby as "he" to avoid confusion with the mother and the midwife but "he" should, as in every other appropriate context, be read as "he or she".

CHAPTER 2: HEALTHY MOTHERS AND NORMAL BABIES IN HOSPITAL

Policy statement

2.1 The care a mother and her baby receive in the first few weeks after the birth are as important as the care given antenatally and during childbirth. A plan should be agreed for each mother's care to ensure that she has the support she needs both during her stay in hospital and after her return home, that the advice she receives is consistent, and that she gains confidence in her role as a parent. To ensure the plan is carried out effectively there should be close liaison between the hospital, GP, midwife and the community support services.

2.2 During her postnatal stay in hospital, whether this is for a few hours or a few days, each mother should normally have her baby at her bedside and take responsibility for his care as soon as she is fit to do so. The baby should not be moved elsewhere unless it is at the mother's wish or unless there are overriding medical reasons.

2.3 Among the reasons for a mother remaining in hospital after the birth of her baby will be her need to rest and have time to adjust to the physiological and emotional changes and new responsibilities which follow childbirth; the aim of the staff should be to facilitate this and to help prepare her to return home as soon as she and her baby are fit and ready to do so. Until that time they should continue to keep the mother and baby under observation, to check that no unexpected complications or illnesses develop, that the baby progresses well, and that his feeding is established.

2.4 All mothers, especially first-time mothers, should be encouraged to discuss with staff anything that is worrying them and staff should find time to answer any questions. It is during the postnatal period that parental attitudes to their responsibilities for the maintenance of their health and that of their children and their expectations of professional aid may be influenced and established. Thus the relationships which are portrayed by the attitudes and actions of midwives, health visitors and doctors are of crucial importance. Openness should be encouraged to facilitate dialogue, to ensure criticism and comment is helpful and to help parents gain confidence in caring for their family.

Care in the delivery suite

2.5 Every mother should be given the opportunity to see and hold her baby immediately after delivery, and to suckle him if she wishes. As soon as staff are satisfied the baby is normal and well and his identity bracelets have been put on, he should be left alone with his parents for a while. Staff in the delivery suite should continue to keep watch, however, over the well-being of both mother and baby, while preparations are being made for their transfer home or to the postnatal area.

The baby's record

2.6 Every baby born in hospital should be allocated a hospital index number, and have his own records folder initiated by the doctor or midwife who attended the birth, before the mother and baby leave the delivery suite. The baby's and mother's notes should be cross-referenced. The baby's sex, birthweight and head circumference should be recorded together with any additional measurements taken.

Transfer from the delivery suite

2.7 Arrangements for any mother who wishes to return home with her baby directly after delivery should have been discussed and agreed with her during the antenatal period. If the community midwife responsible for her postnatal care was not present at the delivery, she should be alerted before the mother leaves hospital so that she can visit her soon after her arrival home.

2.8 When a mother and her baby are due to be transferred to the area used for postnatal care, the midwife who attended her in the delivery suite should introduce her to the midwife in charge. The mother's and baby's notes should be handed over at this time and any cause for concern about mother or baby should be mentioned. The mother should be able to walk to the postnatal area and to carry her baby if she wishes and if it is safe for her to do so. If the father is not available to accompany the mother he should know where she is to be accommodated.

2.9 Once in the postnatal area the mother should be welcomed and made comfortable. She should be told how to get help should she need it, where the toilets and other facilities are, and be given any special guidance she needs about her care and personal hygiene. She should be introduced to other members of staff and to the other mothers sharing her room as and when opportunities arise. If the baby was not weighed and measured in the delivery suite this should be done soon after the transfer and the information recorded in his notes.

Environment

2.10 In all areas used for postnatal care staff should aim to foster a friendly and relaxed atmosphere. Mothers should be free to move around and to talk to each other. Facilities for "out of hours" refreshments should be available. Activities should be so organised as to meet each mother's individual needs for privacy and rest and the pattern of feeding for her baby that she hopes to establish.

General postnatal care of the mother

2.11 Midwives responsible for a mother's care in hospital should try to take opportunities as they arise to give her advice on her own health needs and on the needs of her baby. In particular the needs of mothers who plan to return home shortly after delivery must not be overlooked.

2.12 Every effort should be made to ensure that each mother receives consistent advice from all staff involved in her care. This advice will derive from the general policy agreed between senior medical, midwifery and nursing staff of the unit but will need to be modified to suit each mother's individual needs. All temporary staff as well as permanent staff should be aware of the unit's general policy and the particular advice given to the mothers in their care. Local voluntary groups providing mothers with postnatal support should also be informed of the general policies followed by particular units.

2.13 Advice offered to mothers should include personal care, nutrition, family planning, rubella immunisation and appropriate exercise. Staff should discuss any anxieties mothers may have on these matters and try to answer their questions.

2.14 Appropriate written information should be made available in language each mother will understand. In addition, the midwife or doctor who supervised the birth, should if practicable visit the mother and baby to answer any questions the mother may have about the delivery.

2.15 If a Registrar of Births does not visit the maternity unit, midwifery staff should see that the parents understand the statutory requirement to register their baby's birth, and where, when and by whom this should be done.

Care of the baby

2.16 Normally every mother will have her baby beside her. If they are separated for a short while to allow the mother, or other mothers, to rest undisturbed, she should know where he is and have ready access to him at all times. When a baby is separated from his mother, staff must keep him under regular and frequent observation.

2.17 While in hospital each mother should be given such general guidance as she needs on the care and handling of her baby and advice about the professional help she should seek if any aspect of the baby's health and care worries her once she has returned home. During the baby's stay in hospital the father should be encouraged to share actively in his care.

Infant feeding

2.18 All midwifery and medical staff should endeavour to keep to the infant feeding plan previously agreed with the mother. This is to ensure that she is not confused by conflicting advice and that advice given postnatally does not contradict what she has been told in the antenatal clinic. Staff should pay particular attention to any mother who has not previously had advice on infant feeding or who is not sure what to do.

2.19 Breastfeeding is highly desirable for the baby's development and should be encouraged but a mother who decides not to breastfeed or not to persevere with breastfeeding should not be allowed to feel she has failed her baby. The attitude of midwifery and medical staff towards each mother should be supportive

irrespective of the decision she takes. Demand feeding should be encouraged whether the baby is breast or bottle fed. A mother's wish concerning privacy while feeding her baby should be respected.

2.20 A mother taking any drugs or medicines should ask her doctor for advice on any effects that the drugs may have on breastmilk and the baby and the possibility of a change of drugs. (Further guidance is contained in Chapter 3).

2.21 A bottle feed should not be given to a breastfed baby unless there are overriding medical reasons and then only after discussion with the mother.

Early examination of the baby

2.22 All babies should be fully examined within 24 hours of birth by a doctor experienced in the care of the newborn. The aims should be to check that the baby is normal and well, to look for any congenital abnormalities, to reassure the parents on both counts, and to supplement the information already recorded in the baby's notes. The parents should be encouraged to be present at the examination and to ask questions.

2.23 Since mild jaundice appearing on or after the second day is common, parents should be reassured that investigation or treatment is usually not required unless it persists or increases. Phototherapy and additional fluids are generally required for only a small number of jaundiced babies for whom the indications are clear.

2.24 If a baby is in hospital at the appropriate time for tests to exclude the possibility of certain conditions such as phenylketonuria (PKU) and congenital hypothyroidism, the reasons should be explained even if they have already been discussed with the mother during the antenatal period.

Family visits

2.25 Visiting by the mother's close family and friends should be welcomed at any time subject to her wishes and her need for rest, and to the need to protect the health and safety of other mothers and babies. Additional visitors should be accommodated if the mother wishes and this can be achieved without over-tiring her and inconveniencing others. Staff should try to accommodate those religious observances which the parents feel should be carried out while the mother or baby are still in hospital.

Emotional reactions

2.26 Although most mothers react with pleasure and excitement to the birth of their baby, some feel anxious and depressed, perhaps because of fatigue or discomfort or disappointment with some aspect of the birth. Many experience a transient emotional disturbance, often called "the blues", typically around the fifth day. These mild emotional reactions usually pass quickly and mothers can best be

helped by an opportunity to discuss them and by reassurance that they are common and transient. At this early stage the mother may also be concerned about her lack of feelings for her baby and again can be helped by discussion and reassurance that attachment can take time to develop.

Severe psychiatric disorders such as postnatal depression and puerperal psychosis are dealt with in Chapters 3 and 6.

Going home

2.27 When the mother and baby are ready to go home there should be no unnecessary delay and their midwife and a doctor, if a medical opinion is necessary, should discuss transfer arrangements early in the day. Even at this stage parents may need practical advice on the items which should be readily available at home for the continuing care of the mother and baby. The GP and community midwife should be informed promptly of the arrangements being made and the parents should be told when to expect their first visit by the community midwife.

2.28 If a baby remains in hospital for more than two or three days he should, before going home, be examined again by a doctor experienced in the care of the newborn. The doctor should encourage the mother to ask any questions about the baby and his feeding and should ensure that information to indicate which tests the baby has had and which are outstanding as well as the mother's rubella immunity status is included in the report sent to the GP, community midwife and health visitor. Hospital staff should complete a maternal and a neonatal discharge record form to provide the community health services and the primary health care team with all the information they will usually require. The content of the discharge forms should be reviewed regularly.

2.29 Each mother should be told who will be providing her follow-up care. If she is returning to hospital for her postnatal examination, or should she need to attend any other department, the necessary appointment should be agreed with her and written confirmation provided before she goes home.

ACTION CHECKLIST A

HEALTHY MOTHERS AND NORMAL BABIES IN HOSPITAL

A.1 Is postnatal care given the same status and importance as other aspects of maternity care in each maternity unit's operational policies?

A.2 Does each mother have a plan for her postnatal care and the care of her baby? Are such plans drawn up in consultation with the mother's GP and community midwife?

A.3 Does the unit have the services of a health visitor to act as a link between the hospital and community services?

A.4 Are all babies born in hospital allocated a hospital index number before they leave the delivery suite; and are medical records folders initiated and cross-referenced with their mother's?

A.5 Is each baby's sex, birthweight, head circumference and any additional measurements clearly recorded in his notes?

A.6 If a mother intends to return home with her baby directly from the delivery suite are arrangements always made for her GP and community midwife to be informed promptly?

A.7 Does the midwife who attended the mother in the delivery suite always introduce her to the midwife in charge of the area to which she is transferred for postnatal care? Are the mother's and baby's notes handed over at this time? Are mothers encouraged to hold their baby when transferring from the delivery suite? Is the baby's father encouraged to accompany the mother and baby to the area used for postnatal care?

A.8 Are mothers shown where facilities are and introduced to members of staff and other mothers as soon as appropriate? Are there facilities for "out of hours" refreshments?

A.9 Are babies normally beside their mothers and moved only at the mother's request, or when there are overriding medical reasons? If a baby is separated from his mother is she told where he is and do staff keep him under regular observation?

A.10 Is every mother encouraged to look after her own baby as soon as she is able? Is the father encouraged to share actively in his baby's care?

A.11 Is each mother informed of the benefits to her baby of breastfeeding? Are her wishes clearly recorded in her notes? Are mothers who do not wish to breastfeed shown how to prepare infant feeds? Are there clear instructions to staff about when supplementary bottlefeeds to breastfed babies may be given?

A.12 Is advice on breastfeeding always given by staff qualified to do so? Do they ensure that members of appropriate voluntary organisations who may assist in the establishment and maintenance of breastfeeding are aware of the general policy adopted by the unit and the advice given to individual mothers? Are breastpumps and other aids available for those mothers who need help to establish or maintain lactation?

A.13 Is care taken to ensure that activities in the areas used for postnatal care do not impose unnecessary restriction on the mothers nor hinder infant feeding?

A.14 Does the doctor or midwife who supervised the delivery visit the mother postnatally to answer any questions she may have about her confinement?

A.15 Is there provision for detailed advice, practical instruction and supervision, as required, on all aspects of mothercraft and personal care? Is written information available in language the mother will understand?

A.16 Are all babies examined within 24 hours of their birth by a doctor experienced in the care of the newborn? Are parents given the opportunity to be present at the examination and are they encouraged to ask questions?

A.17 Are the reasons for any tests to be undertaken on the baby clearly explained to the parents?

A.18 Is there unrestricted visiting in the postnatal period for fathers and close relatives? Are other relatives and friends welcomed? Is there adequate privacy for other mothers when visitors are in close proximity?

A.19 Do staff check that parents know of the requirement to register their baby's birth and where, when and by whom this should be done?

A.20 When a mother is due to go home are her GP and midwife informed promptly? Are the parents told when the midwife will call for the the first time? Are the parents advised of the importance of registering their baby with a GP?

A.21 Is a maternal and neonatal discharge record form completed for each mother and baby when they go home? Is the content of the forms regularly reviewed to ensure they contain all the necessary information?

A.22 Are any subsequent appointments to attend the hospital agreed with the mother before she goes home?

CHAPTER 3: MOTHERS WITH SPECIAL NEEDS

This Chapter deals with mothers with special needs other than those following the birth of a baby with a malformation or risk of handicap, or following a stillbirth or early neonatal death; these are dealt with in Chapters 5 and 7 respectively.

Policy statement

3.1 Each unit's operational policies will need to cover the special postnatal care needs of those mothers who may have had a complication during pregnancy or childbirth, a pre-existing medical condition or handicap, or whose particular social circumstances may affect their health and ability to care for their baby. The individual care plan agreed for each mother with such special needs should be kept under continual review.

3.2 The objective should be to ensure that every mother, notwithstanding her special circumstances, receives full postnatal care and is given what assistance she may need in preparing to return home and, so far as she is able, in assuming responsibility for the care of her baby.

Mothers with handicaps

3.3 For a mother with a handicap or pre-existing medical condition the management of the delivery and any problems likely to arise in the postnatal period should have been discussed with her during her antenatal care, but the agreed care plan should subsequently be reviewed as necessary.

Care following a complicated birth

3.4 Complications in labour which can affect the method of delivery may arise suddenly and every mother should understand that the plan agreed for her postnatal care may have to be changed. The mother's special needs will mostly be short term, for instance a temporary incapacity following a Caesarean section. In such cases practical ways should be found of facilitating contact between the mother and her baby if she is unable to hold and care for him easily. Unnecessary separation of mother and baby should be avoided.

3.5 Every mother who has had a complicated labour or birth should be visited during her postnatal stay by an experienced member of the medical staff, normally the doctor who performed or supervised the delivery, to discuss what happened and why, and the implications for the future. The doctor should ensure that there is an accurate account of events in the casenotes, so that the mother and father subsequently receive consistent advice and information from all staff, and should

record additionally any significant points which arise in discussion. If a mother continues to be concerned about events surrounding the birth of her baby, a further discussion should be arranged before she goes home. A written account of whatever has been told to the mother should be included in the report sent to her GP, community midwife and health visitor.

Emotional and psychological needs

3.6 Some mothers may have special needs which arise from their social or domestic circumstances or result from an emotional disturbance which develops after the birth of their baby. Whenever possible, potential difficulties should have been discussed with each mother during the antenatal period especially any difficulties unsupported or vulnerable mothers or mothers who have a previous history of mental illness or addiction, might have to face. Some problems will not become apparent until after the baby has been born, and staff should be alert to any sign of these in the postnatal period.

3.7 Hospital midwifery and medical staff should be aware of and watchful for early signs of puerperal psychosis or postnatal depression, particularly if a mother has suffered from this type of illness before. Mothers and their families who are worried about these conditions should be reassured about the generally favourable outlook if appropriate therapy is given. Staff should also take note of any sign that either parent has an abnormal attitude to their baby. Observations about any of these conditions should be carefully recorded and passed on to the appropriate members of the primary health care team and, if appropriate, a social worker. The support needed by such mothers when they return home with their babies is discussed further in Chapter 6.

Problems in breastfeeding

3.8 General advice on infant feeding is given in Chapter 2. There are few instances, even when the mother is suffering from an infectious illness, when breastfeeding is not possible. Breastfeeding should not be discouraged solely because the mother is under medication unless careful enquiry has confirmed that the drug or the dosage being used is likely to be harmful to the baby via the breastmilk. Doctors prescribing drugs should have regard to up-to-date information on these aspects. If there is doubt it is often valuable to seek the view of a paediatrician or clinical pharmacologist. The mother should be informed of the effect of a drug both on herself and her baby, and her doctor should discuss the implications with her. Midwifery staff should be informed of all drugs prescribed for a mother in the postnatal period and advised how they may identify any effects on the baby.

3.9 Other problems may affect the maintenance of breastfeeding; these include cracked or sore nipples or breast abcesses. Mothers should be advised that such conditions do not necessarily mean that breastfeeding should be discontinued but may indicate a temporary change to the use of expressed breastmilk until the condition improves.

Accommodation

3.10 A mother with a condition which requires specialist treatment should be cared for within the maternity unit unless intensive care facilities or other specialist care are essential.

3.11 If the mother is to be transferred to another ward or hospital, her baby should normally go with her; if this is not possible, or is inadvisable, staff should liaise with those on the ward to which she is moved to ensure that mother and baby can be together as much as possible. Staff looking after the mother should ensure that she is kept informed of her baby's well-being and progress. Midwifery care should continue to be provided for the mother wherever she is being nursed, and a midwife should visit her as often as necessary to ensure that her particular needs as a newly delivered mother are not neglected.

3.12 Although mothers may enjoy the company of others all will require periods of privacy and quiet. Single rooms will be necessary for mothers who require high dependency facilities or isolation care or who need a greater degree of supervision and observation or quiet surroundings.

Mothers of babies who are to be fostered or adopted

3.13 When a mother has decided beforehand that she wants her baby to be fostered or adopted, senior staff should ensure that all staff looking after her understand the plan for her and her baby's care. This should have been discussed and agreed with the mother during the antenatal period and should cover the mother's contact with the baby and the timing of their separation. Although the mother may have decided to part with her baby she may nevertheless wish to breastfeed him and to care for him while in hospital, and she should not normally be discouraged from doing so. The plan for the care of the mother and baby must recognise that she may change her mind about her decision or about aspects of her baby's care.

3.14 A mother who refuses all contact with her baby following his birth may still need time to come to terms with her decision. If she wishes, she should be told where and by whom her baby is being cared for and given news of his well-being prior to adoption. She should be offered counselling, if appropriate, and staff should be supportive of her whatever decision she has taken about her baby's care. Each mother should be asked whether she wishes to have a single room or to share a room with others, and her wish should be met.

Mothers of babies taken into care

3.15 Senior staff should be involved whenever a baby has to be taken into care against his mother's wishes. They should see that the midwife concerned has support when dealing with the mother and family members, and that all staff understand the legal situation concerning the baby. If the need for a care order had been foreseen, the plan for the care of the baby should have been discussed and agreed at a formal case conference before his birth, and should be known to all staff working on the unit. Every effort should be made to give the mother such privacy as she needs in her distress and support in her relationships with other mothers and her own family.

Family support

3.16 The support of family and close friends may be of particular importance to a mother whose pregnancy or delivery has not been straightforward and in such cases frequent visits should be encouraged provided this does not interfere with her own needs or those of other mothers in the same room. Staff should check with her that she is able to cope and that her visitors do not prevent her from getting adequate rest.

3.17 Staff should offer the baby's father advice and guidance on the extra care and support the mother may herself need when she returns home, and on any help she may need in caring for the baby. Staff should recognise the strain on the father and other members of the family when the mother is ill and should try to build up his confidence in looking after her and in helping to care for the baby.

Preparations for going home

3.18 Each mother's GP, community midwife and health visitor should be informed in advance when she is likely to return home so that they may have the opportunity to visit her in hospital and make arrangements to continue her care. On occasions, consultations with the GP and, if appropriate, the Social Services Department, on the timing of the mother's return home may be useful. In any event the GP and community midwife must be notified of the day the mother leaves hospital. The mother should be given letters to hand to her community midwife and GP and, if appropriate, a supply of drugs to use at home until she can see her doctor. Arrangements for any subsequent appointment at the hospital should be agreed with the mother and written confirmation given to her before she goes home.

Readmission to hospital

3.19 If a mother needs to be readmitted to hospital during the postnatal period, every effort should be made to accommodate her baby as well. The mother should be admitted to a ward where if she is able she can look after her baby and where his welfare and safety can be provided for. Her midwife should be consulted and involved in the care of mother and baby as appropriate.

ACTION CHECKLIST B

MOTHERS WITH SPECIAL NEEDS

B.1 Do every maternity unit's operational policies cover the care of women who have special needs following the birth of their baby? Is the objective to ensure that all mothers receive full postnatal care wherever they are?

B.2 Where such needs can be foreseen, is a care plan always agreed with mother during the antenatal period, covering her own care and the care of her baby? Is the plan reviewed to take account of changes in circumstances or in the mother's views?

B.3 Are practical ways found to facilitate contact between the mother and baby during recovery from a Caesarean section or other procedure, if she is unable to hold or care for him easily?

B.4 When complications occurred in labour or childbirth, is the mother visited during her postnatal stay by whoever performed or supervised the delivery to discuss events? Are any significant points arising from the discussion always recorded in the mother's notes? Is a written account of what has been told to the mother included in the report sent to her GP, community midwife and health visitor?

B.5 If a mother is moved to another ward or hospital does her baby normally go with her? If her baby cannot stay with her are arrangements made for the mother and baby to be together as much as possible? Are arrangements always made for the mother to be regularly informed of her baby's health and progress? Is a photograph of the baby provided for the mother?

B.6 Is a midwife responsible for a mother's postnatal care irrespective of where she is accommodated within the hospital?

B.7 When prescribing, do doctors have access to up-to-date information such as the British National Formulary, concerning the effects of drugs and dosages on the baby when transmitted via breastmilk?

B.8 Are mothers who have special needs or difficulties in feeding their babies given expert advice and practical assistance? Are breastpumps and other aids available for those mothers who need help to establish or maintain lactation?

B.9 When a mother is handicapped or ill, do staff show and advise the father on how to care for both the mother and baby when they return home?

B.10 If a mother is likely to experience difficulties in looking after herself and her baby when she returns home, is a social worker informed and involved in her care along with the community midwife and health visitor?

B.11 Are members of the primary health care team informed and, if appropriate, a social worker, if there are any causes for concern in the mother's emotional state or attitude towards her baby? Are staff aware of and watchful for early signs of puerperal psychosis or postnatal depression? Are any observations made by staff carefully recorded?

B.12 Before discharging a mother who has been recovering from an operation or who has had other difficulties, do the doctor and midwife concerned ensure that she:

— is given up-to-date information regarding her condition;

— if appropriate, has an appointment for her re-admission or for a postnatal examination at the hospital clinic or other out-patient attendance;

— is told the results and significance of tests and investigations as soon as possible?

B.13 If a mother needs to be re-admitted to hospital during the postnatal period, for whatever reason, is the care of her baby discussed with her and her family beforehand and are arrangements made for the baby to accompany her if practicable?

B.14 Do each unit's operational policies specifically cover the practice recommended in this chapter when a baby is to be adopted or fostered or has to be removed to a place of safety after birth? Are these policies agreed with the local Social Services Department and known to all staff? Are steps taken to ensure that staff working on the unit understand the agreed plan for the care of the mother and of the baby who is to be adopted or fostered or taken into care?

B.15 Are there facilities for a photograph to be taken of a baby due to be adopted or placed in long term foster care to be kept with his records in case it is requested later?

B.16 Is suitable hospital accommodation available for a mother whose baby is to be adopted, fostered or taken into care? Is a social worker readily available to provide support and counselling for such mothers if required?

CHAPTER 4: SMALL AND ILL BABIES

Policy statement

4.1 A baby should not be separated from his mother unless absolutely necessary for the care of either: contact between the small or ill baby and his mother and father is as important for his development and well-being as for any other baby. Babies should whenever possible be looked after alongside their mothers in the areas used for postnatal care, even if a measure of extra care is required. Only babies who need continuous skilled supervision by nursing and medical staff or who require care in hospital for a prolonged period should be admitted to a neonatal unit, to which parents should have ready access.

4.2 Babies should as far as possible be cared for in the District where they are born. Every maternity unit should be prepared to meet the immediate needs of all babies delivered in it; but because not all maternity units and associated neonatal units have the necessary facilities or staff expertise to meet the continuing needs of all small or seriously ill babies, some may have to be transferred to units which have such facilities. Each Region should have a strategy for the development of neonatal care on the lines described below.

The neonatal unit

4.3 The term "neonatal unit" is used to describe any area designated for small or ill babies who cannot be cared for with their mothers in the areas for postnatal care. All babies needing intensive care will be admitted to such a unit, together with a proportion of those needing special care. As staffing levels and expertise build up however, more babies can be expected to receive appropriate forms of special care not in the unit but with their mothers in the postnatal areas. The extent of the need for special care in neonatal units, will depend on the one hand on the ability to care for babies in the postnatal area and on the other on the number of babies who progress to special care from intensive care.

Provision of intensive care

4.4 Within each Region there will be a need for one or more designated Regional Perinatal Centres, able to maintain care for the mother and intensive care for the baby for long periods. Mothers can be referred antenatally to such units when the birth of a baby who is likely to require long term intensive care is anticipated. All but the smallest maternity units should have their own neonatal unit with staff able to initiate intensive care for very small and ill babies whenever required, and to maintain such care at least until the baby can be transferred to a unit with the necessary facilities.

4.5 The function of Regional Perinatal Centres should be to provide the necessary back-up to Districts and to take the lead in training medical and nursing staff in the high level of expertise required and in research directed towards advancing standards and effectiveness of perinatal care.

4.6 A Regional policy of total centralisation of neonatal intensive care in Regional Perinatal Centres is not recommended. This creates difficulties in maintaining family links. District neonatal units need moreover to develop in parallel with Regional Centres their ability to provide some intensive care because anticipation, prompt recognition and early intervention in neonatal disorders may prevent deterioration and so will minimise the need to transfer the baby elsewhere.

Regional strategy

4.7 To ensure adequate provision of intensive care facilities each Region should produce as a matter of urgency a strategy for the provision of neonatal intensive care having regard to the principles outlined above and a plan for its early implementation. The strategy should estimate on the basis of up-to-date information on past trends and anticipated developments what proportion of babies born in each unit are likely to need special and intensive care. It should estimate the total number of neonatal intensive care cots required throughout the Region and where these should be provided, and include a programme and timetable agreed with the appropriate Districts outlining the steps to be taken to make good any shortfall within the planning period. In doing this Regions should have regard to the latest advice from the British Paediatric Association and other appropriate professional bodies. The plan should build on the actual and potential ability of individual units to care for small or ill babies, and assess the extent to which District needs will have to be met by Regional Perinatal Centres.

Monitoring and evaluation of neonatal care

4.8 Regional Health Authorities should ensure that adequate information is collected on the daily caseload of each maternity and neonatal unit and on the level and type of neonatal care given and use this information as a basis for future planning where it indicates a need for change in provision.

4.9 Clinicians should have access to information which will help them monitor the outcome of neonatal intensive care in terms of survival and the quality of life achieved.

Provision for neonatal surgery

4.10 The Regional strategy should include provision for neonatal surgery. Babies requiring immediate surgery to correct a life threatening condition should be admitted without delay to a special neonatal surgical unit. Ideally, such facilities

should be sited within Regional Perinatal Centres. There should be at least one such unit in each Region able to provide continuous care and supervision of the baby by medical and nursing staff before and after the operation, although for neonatal cardiac surgery referral may have to be to a designated Supra-Regional centre.

4.11 It is particularly important that such surgical units and centres have sufficient and suitable accommodation for parents and that arrangements are made for mothers to receive postnatal care.

Arrangements for transfer

4.12 On those occasions when the birth of a very small or ill baby can be foreseen the mother ideally should be delivered in a consultant maternity unit in a hospital with appropriate facilities for providing neonatal intensive care. Any arrangements for transfer before delivery should be made in consultation with both the obstetrician and paediatrician at the receiving centre.

4.13 Regional Perinatal Centres should ensure in discussion with District Health Authorities that appropriately trained staff and suitably equipped transport are always available for the transfer to a neonatal unit of babies whose need for intensive care was not foreseen. The arrangements for emergency transfer must be understood by all medical, nursing, midwifery, administrative and ambulance staff and be kept under review in the light of changing circumstances. They must allow for the occasional transfer of babies born in GP units, or private maternity units and of babies born at home.

Environment of neonatal units

4.14 Although the appearance of neonatal units will necessarily reflect their clinical function, staff nevertheless should do what they can to make the unit as welcoming as possible to parents and siblings. Decorating the ward, providing a nursery atmosphere and displaying photographs of children who were once patients are all practices to be encouraged.

General care

4.15 The handling of very small and ill babies should be carefully planned as they are physiologically unstable and so particularly vulnerable to environmental changes, prone to respiratory problems and at risk of infection. Units should have clear agreed procedures for monitoring and preventing these problems and for their management should they occur. The emotional as well as the physical needs of babies should be taken into account in the plans for their care and babies who remain in neonatal units for several weeks should also have their developmental needs considered.

Contact between parents and their baby

4.16 Normally parents should have unrestricted access to their baby whether he is cared for in the postnatal area or in a neonatal unit. If a baby requires care which precludes his being nursed beside his mother, provision should be made for the mother or the father to sleep in or near to the neonatal unit if they wish. In such cases the mother should continue to receive the same care and attention from midwives concerning her own health as she would have received had she remained in the postnatal area. Care should be taken that meals are available to mothers staying in the unit.

4.17 If a baby has to be transferred to another hospital arrangements should be made for the mother to stay with him and to receive her postnatal care in that hospital. If the mother cannot be near her baby, the opportunity should be offered to the father to go with him and to the mother to be transferred as soon as possible afterwards. Staff looking after the mother in the interim should ensure that she is kept informed of the treatment her baby is receiving and of his progress. While they are apart the mother should have a photograph of her baby.

4.18 Staff should explain what is being done for the baby, what the equipment is for, and listen and respond to parents' questions. Some units provide explanatory leaflets or booklets which can be helpful and reassuring to parents. The dressing of babies in suitable, attractive and well fitting clothes as soon as their condition permits helps parents to look forward to their baby's normal development. Parents should be encouraged to touch and, when he is well enough, to hold their baby and gradually as his condition improves, to take over the care they will be giving when he goes home.

Infant feeding

4.19 Some small or ill babies are unable to be breastfed at first. A mother who is intending to breastfeed her baby once his condition allows will need particular encouragement to establish and maintain lactation and should be shown how to express her milk. The mother should be given every encouragement and any necessary help to feed her baby whatever method is used.

Family contact

4.20 Close relatives should be able to see the new baby whether he is in the postnatal area or in the neonatal unit provided this does not interfere with his need for rest and treatment.

4.21 A very small or ill baby may be in hospital a long time and his mother may have to return home many weeks before him. In this situation there is a need to guard against loss of contact with the parents, particularly when they already have other children to claim their attention. Staff in neonatal units will need to be alert for signs of parents distancing themselves from their baby and should take steps to notify the GP, community midwife, health visitor and social worker if they cease to

visit. The social worker should try to determine if parents have any financial or other difficulties which prevent their visiting the baby and advise them of the sources of assistance available. When the baby has been referred to a centre for neonatal intensive care or neonatal surgery, consideration should be given to moving him into a hospital nearer to his parents' home as soon as his condition permits.

Parent support groups

4.22 Mothers of small or ill babies are especially in need of support. Often parents who have had a similar experience can be very helpful, and staff in some units have already assisted in setting up parent support groups for this purpose. Hospital staff should take a continuing interest in such groups and encourage them to give the help and support the parents need.

Going home

4.23 A baby who has spent considerable time in a neonatal unit will need to be prepared as far as it is practicable while in hospital for the different environment of his parents' home. It is helpful for his mother, or his father, to have full responsibility for his care and accommodation should be made available for a parent to stay with him in hospital for a period prior to their going home. There should be well understood arrangements for the transport home of mother and baby. The other procedures for transfer home should be similar to those for any other mother and baby (see Chapter 2).

Care at home

4.24 Arrangements for the follow up or re-admission of babies who have received intensive care and who may have continuing problems, should be made before the baby goes home. The senior doctor responsible for the baby's care should take time when the parents are preparing for the baby to go home to discuss fully his condition and future arrangements. In cases where an abnormality or handicapping condition has been detected or is suspected an early appointment with the consultant paediatrician should be made.

4.25 Senior staff of the unit should notify the GP, community midwifery and health visiting services and other appropriate community services at the time the mother and baby are preparing to go home. At home, the mother will need continuing support from a midwife and health visitor whilst she gains confidence in looking after her baby. If the baby is discharged early, in line with the neonatal unit's policy, but still requires some form of special care, the health visitor or midwife who supports the mother should have experience and training in providing that care and should be able to liaise easily with the neonatal unit if necessary. The genera care and support provided for mothers once they return home with their babies is discussed further in Chapter 6.

4.26 Health Authorities should consider the possibility of extending their community service to provide some special care for babies at home thereby facilitating their earlier discharge from hospital.

ACTION CHECKLIST C

SMALL AND ILL BABIES

C.1 Does the Region have a strategy, programme and timetable for the development of neonatal care throughout the Region as described in this chapter? Does this indicate the different levels of neonatal care to be aimed at in each maternity unit and Regional Perinatal Centre?

C.2 Does each maternity unit have operational policies covering procedures to be followed in caring for small or ill babies? Do these policies emphasise the need for a baby to be cared for alongside his mother if at all possible? Do senior staff ensure these are understood by all staff working in the unit and where appropriate by parents attending their baby?

C.3 If the maternity unit has a neonatal unit are staff capable of initiating and maintaining intensive care until at least such time as the baby can be transferred to a unit with the necessary facilities?

C.4 Does each neonatal unit carry out a daily census of the caseload and level and type of care provided? Are staff aware of the classifications of care put forward by the British Paediatric Association? Do Regional Health Authorities use this information as a basis for reviewing plans?

C.5 Do clinicians have access to information which will help them monitor the outcome of neonatal intensive care?

C.6 Does each maternity unit have ready access to a designated Regional Perinatal Centre to which mothers who are expected to have a baby who will require intensive care can be referred for care and delivery?

C.7 Do the staff of each maternity unit understand the arrangements for the emergency admission or transfer of babies to an appropriate neonatal unit? Are arrangements for the acceptance and transfer of babies to Regional Perinatal Centres satisfactory? Are arrangements monitored regularly to maintain them at a high point of efficiency?

C.8 To help Regions assess any deficiencies in facilities for neonatal intensive care are records kept of the number of babies refused admission by Regional Perinatal Centres, the reasons for this and the referring District?

C.9 If a baby has had to be referred to a unit providing intensive care in another hospital, are arrangements made for his transfer back to a hospital nearer his parents' home as soon as his condition permits?

C.10 If a baby has to be separated from his parents is particular care taken to keep them informed of his treatment and progress? Are explanatory leaflets about the neonatal unit readily available? Are there facilities for photographs of the baby to be sent periodically to the parents?

C.11 Does the plan for the care of each baby take into account his emotional as well as physical needs? Does the plan for a baby remaining in the unit for several weeks include his developmental needs? Are all such plans reviewed regularly?

C.12 Does the environment of the neonatal unit provide as much of the family atmosphere as is compatible with clinical needs?

C.13 Are babies dressed in suitable, attractive and well fitting clothes as soon as their condition permits?

C.14 Is accommodation for parents available in or near to each neonatal unit? Is a social worker available to advise parents who face financial or other difficulties in visiting their baby, or who have other problems requiring social work support?

C.15 While a baby is in a neonatal unit are parents encouraged to be involved in his care and does this include progressively taking over responsibility for his care? Are parents told about the baby's treatment and care, what the equipment is for and invited to ask questions?

C.16 Are mothers intending to breastfeed when their babies are well enough helped to establish and maintain lactation? Are breastpumps available for mothers to use whether in hospital or at home?

C.17 Is there unrestricted visiting for parents in the neonatal unit? Are visits by children and close relatives facilitated?

C.18 Are the GP, community midwife, health visitor and the social worker alerted if parents cease to visit a baby receiving long-term care in the neonatal unit or if he appears in any other way at risk of being rejected by his parents?

C.19 Does every neonatal unit know how to contact suitable parents who have formerly had small or ill babies and who can give support to new parents, if they need it?

C.20 Are mothers encouraged to stay in the unit and care for their babies during the period immediately before the baby goes home?

C.21 Are staff working in the neonatal unit aware of and watchful for early signs of postnatal depressive illness or other problems in the mother?

C.22 When a baby who has been receiving intensive care is ready to go home are the GP, community midwife, health visitor and, if appropriate, the social worker consulted in advance and informed of the date?

C.23 Is accurate and up-to-date information available to the GP, community midwife and health visitor when the baby arrives home?

C.24 If a unit has a policy of early discharge of babies who will continue to require some form of special care at home, are health visiting and community midwifery staff adequately trained to provide that care? Has consideration been given, if the demand justifies it, to the provision of a special domiciliary nursing service for such babies?

CHAPTER 5: BABIES WITH A MALFORMATION OR RISK OF HANDICAP

Policy statement

5.1 This Chapter is concerned with babies with a malformation and babies with conditions which can or do give rise to handicap. It excludes babies who are stillborn or who die shortly after birth, who are the subject of Chapter 7.

5.2 Decisions about the care of a baby born with a malformation or risk of handicap must involve parents and staff of the maternity and neonatal unit, including a social worker when appropriate, working as a team. The team should be well informed on the support likely to be available to parents and ensure that they are given consistent help and advice from the outset. The primary health care team who will be responsible for the mother and baby must be informed immediately and should also be involved as soon as practicable.

5.3 There should be full discussion with the parents to enable them to understand the nature of their baby's condition, and its implications.

Diagnosis before birth

5.4 When it is anticipated that a baby may be born with a condition for which surgical or other specialised treatment may be required, arrangements should be made for the baby to be delivered in a consultant unit which has ready access to the neonatal unit best suited to manage the particular condition. So far as is practicable, a plan for the baby's care should be drawn up with the parents' understanding and agreement. Staff caring for the mother through pregnancy and childbirth should be on their guard against creating either excessive despondency or unrealistic expectations in the parents. They should draw attention to and advise on the support which will be available subsequently.

Informing the parents after the birth

5.5 When an abnormality or a handicapping condition is apparent or suspected in the baby, both parents should be seen without delay in private by an experienced doctor, preferably with the midwife present who will be responsible for the mother's postnatal care; but information should not necessarily be withheld from one parent simply so that both can be told together. While an expert paediatric opinion is awaited, midwifery and medical staff in the delivery suite should not avoid contact with the parents, and senior staff should discuss the position with them as accurately as they can. Staff should acknowledge if they are unable to answer some questions rather than provide the parents with misleading information.

5.6 The paediatrician at the initial discussion should try to explain clearly the baby's condition and any tests that may be required before a definite diagnosis can be made and possible management plans drawn up. He must be prepared to have a series of meetings with the parents to develop their understanding of their baby's condition and to help them come to terms with their grief, anxiety, guilt or loss of self-esteem, all of which are common reactions. The first of the meetings should normally take place within two days of the initial discussion.

5.7 Great care must be taken to help parents understand the possibility of treatment for the baby, his prospects and the type and level of support available. They should be given an opportunity to discuss their worries about the possible causes of the baby's condition even if no definite opinion can be formed. The paediatrician should consider with them the need to involve in discussions other family members, other professionals such as a social worker, a health visitor or an experienced representative from a relevant voluntary organisation and, when appropriate, a religious counsellor. The GP should be kept informed and it may be helpful to involve him in these discussions at any early stage.

5.8 Simple accurate written information about the condition which the baby has, as far as it can be assessed, should be provided to serve as a reinforcement of what the parents have been told and to help them explain the condition when talking to relatives and friends.

Immediate support for parents

5.9 Both parents will need continuing support while they consider their baby's future and how best he should be cared for. They will need privacy and time to talk and to begin to come to terms with their feelings. The mother should, if she wishes, be given a separate room. The parents should have access to a telephone so that they can speak privately to relatives. Privacy should be extended to other family members and friends who may also be distressed.

5.10 The parents should be free to see and touch their baby and be encouraged to hold him, if his condition permits. If it is thought that a disfiguring malformation might cause distress, the baby should be suitably wrapped before being handed to them so that the extent of the abnormality may be revealed gradually. Staff should not react precipitately if the parents seem initially to reject the baby as this rejection is often short-lived. Sympathetic counselling and a realistic appraisal of the baby's prospects should be given. Parents will be greatly helped in accepting their baby's condition if staff demonstrate by the way they care for him that he is lovable and valued.

Decisions about the baby's care

5.11 Staff should explain to parents the continuing support they can expect from the hospital, community and social services. Parents who feel unable to cope with their baby on their own should have the opportunity to discuss with a social worker the various kinds of support the local Social Services Department can provide,

including day care and periods of respite care. They should also be given the opportunity to discuss the problems they foresee with couples who have had to face similar problems.

5.12 Parents who, after full discussion, still foresee extreme difficulty should not be made to feel they have to care for their baby. If they eventually decide that they cannot care for their baby at home their views should be accepted without reproach and alternative facilities must be arranged. The parents' decision should not preclude their further involvement in discussions about the baby's treatment or in agreeing arrangements for his longer term care.

Decisions about treatment

5.13 In some cases before a decision is taken concerning the nature and level of treatment there needs to be full discussion between the consultant responsible and senior members of the paediatric team and the parents. The aim should be to reach a consensus having regard to all the circumstances. This should be pursued but where exceptionally it proves unattainable, all should be helped to understand that a decision will have to be taken in the baby's best interest and is the responsibility of the consultant in charge.

Longer-term support

5.14 The paediatrician should inform the family's GP, community midwife, health visitor and social worker of the baby's condition so that they can make appropriate plans for his future care. There should also be agreed arrangements for notifying the District Handicap Team or other machinery for liaison with the Social Services Department and other agencies, and for notifying the designated doctor with responsibility for the community child health services in the area in which the parents reside, so that the statutory duty of informing the Education Authority can be discharged.

5.15 Every District should have a District Handicap Team to ensure that services required by parents of a handicapped child can be co-ordinated through a named key worker. District Handicap Teams should provide a framework within which all the needs of the relatively few children with severe handicap can be met, including their needs for psychological and psychiatric help. The relationship between the team and those responsible for the provision of services needs to be clearly established and the team will also need to have close links with professional staff concerned with the assessment and support of children with less severe and less complex problems.

5.16 Before the mother leaves hospital, the paediatrician should explain the action taken and what is planned, and the various support services that may be involved in the subsequent care of the baby and his family. The paediatrician should check that arrangements have been made for a follow-up out-patient appointment for the baby and that referral has been made to the District Handicap Team if necessary. The GP, community midwife, health visitor and social worker must be informed in advance of the mother's return home with her baby.

5.17 An opportunity should be given before the mother leaves hospital, and arrangements made, for the parents to see the senior obstetrician responsible for the mother's care or the paediatrician responsible for the baby's care and, where appropriate, for referral to a genetic advisory clinic. Thus the parents can receive an expert opinion on the prospects and options for the management of a future pregnancy.

5.18 On return home the parents of a handicapped baby face many practical problems: as well as managing their own adjustment they may need to help any other children adjust to the new baby and understand the demands he will place on the family. They will also have to cope with the reaction of relatives, friends and neighbours. Primary care and paediatric teams must ensure that the parents understand and can easily obtain the help offered by appropriate voluntary organisations, especially in meeting other suitable parents with a similarly handicapped child. Information should be available on national organisations as well as on local groups.

Minor malformations

5.19 When a baby is born with an abnormality or malformation which is not life threatening nor likely to result in a handicap, parents should still be seen as soon as possible after the birth by a paediatrician, who should explain the condition and any treatment plan proposed, and, if appropriate, introduce the staff who will be involved in the future care of the baby. Recent "before and after" photographs of other babies with the same or similar condition showing an encouraging outcome may be helpful and should be available.

ACTION CHECKLIST D

BABIES WITH A MALFORMATION OR RISK OF HANDICAP

D.1 Does each maternity unit have clear written procedures for staff to follow when a baby is born or is expected to be born with a malformation or a possible handicapping condition? Do staff work as a team and seek from the outset to involve parents fully in decisions about their baby's care?

D.2 When it is anticipated that a baby may be born with a condition requiring specialist treatment, are arrangements made for the mother to be delivered in a consultant maternity unit with ready access to the specialist facilities required?

D.3 Is up-to-date information available to staff in each maternity unit on who to approach immediately and how to mobilise the various sources of help and advice which are available locally for the parents of a child born with a possible handicapping condition? Is this information made available to parents from the outset?

D.4 If a baby is born with a suspected or evident handicapping condition are the parents always given an opportunity without delay for full discussion with the paediatrician concerned? Is the need for any investigations before a definite diagnosis can be made always explained to the parents in a manner and language they understand?

D.5 Does the paediatrician have a series of meetings with the parents to help develop their understanding of the baby's condition and does the first of these occur within 48 hours of the initial discussion?

D.6 Does the paediatrician consider with the parents the need to involve in discussions other family members, other professionals such as a social worker, a health visitor or someone from a relevant voluntary organisation, and when appropriate a religious counsellor? Is the GP kept informed of developments and involved in discussions at an early stage? Are any observations about the parents' attitude to their baby recorded with the same care as any other clinical observation?

D.7 Are parents given written information when appropriate about the condition their baby has? Does the unit have the names of parents of babies with a similar condition and who are likely to be supportive? Does the unit have the names and addresses of local representatives of voluntary organisations who offer written information and support?

D.8 Does each maternity unit have a named social worker to advise parents of a handicapped child of full details of the support available to them?

D.9 Is there a District Handicap Team and does it ensure that the services required by the parents of a handicapped child are co-ordinated through a named key worker? Are there agreed arrangements for notifying the designated doctor responsible for the community child health service in the area in which the parents reside so that the Education Authority can be informed?

D.10 When a handicapped baby is to go home with his parents are the GP, community midwife, health visitor and social worker informed in advance?

D.11 Are recent photographs of babies who have had similar minor malformations at birth and an encouraging outcome available to show to parents?

CHAPTER 6: MOTHERS AND BABIES AT HOME

Policy statement

6.1 Much of the postnatal care of mothers whose babies are born in hospital will be undertaken at home by the GP, community midwife and health visitor. For a mother delivered under the care of a GP, whether in hospital or at home, her postnatal care and the care of her baby will be an integral part of the total care provided by the GP and an important extension of family care. For all mothers it is the responsibility of the primary health care team to see that care is completed and to provide such advice and assistance as each mother and her family may need in caring for the baby. They should ensure that the parents know where they can get help and advice both during and after the postnatal period, as and when the need arises, and discuss with them how they may make best use of child health services. The GP should be accessible and take the initiative in visiting the mother and baby at home.

Handover of care

6.2 If a mother has to stay in hospital for more than 5 days after the birth her community midwife should try to visit her in hospital before she goes home and, if practicable, take some part in her care. In all cases, particularly when a shorter stay is planned, the community midwife should either have been involved in the mother's antenatal care, or have introduced herself to the mother during the antenatal period and have visited her at home if possible.

6.3 The midwife's postnatal visiting responsibilities should not prevent a flexible arrangement whereby the health visitor and midwife visit together if this is necessary to meet the needs of individual mothers. Relevant written and verbal information should be exchanged between midwife and health visitor when handing over or sharing care.

Care of the mother

6.4 Mothers who have taken advantage of a short-stay scheme will receive most of their postnatal care from their community midwife. Advice they receive in their own home must be consistent with advice they may have been given previously in hospital. The midwife should take special care to see that these mothers, and also mothers whose babies have been born at home, know how to recognise and report any signs of ill health or complications in themselves and the baby.

6.5 If it appeared during antenatal preparation that the father would not be able to help at home and if the mother is unable to obtain assistance from relatives and friends, her midwife or health visitor should advise on the availability of home help services from statutory or voluntary sources.

6.6 The early postnatal days may be anxious ones for the mother and her new family when minor ailments are manifested. The mother should be encouraged to discuss any worries she may have with her GP, midwife or health visitor. Her GP should be prepared to visit a mother at home if she has difficulty attending the surgery. Every mother should be offered advice about postnatal exercises and nutrition, and about family planning facilities and rubella immunisation as appropriate.

Help with infant feeding

6.7 A mother who wishes to breastfeed should be advised on how to establish and maintain this after she has returned home. She may well need support particularly if there is social or family pressure to change to bottle feeding. Mothers who choose artificial feeds should be given expert advice particularly if they feel troubled by conflicting opinions from friends and relatives concerning the choice, preparation and frequency of feeds.

Care of the baby

6.8 As the trend towards early transfer home from hospital continues, it is particularly important that babies who have only had one examination in hospital are seen and assessed by their GP during the neonatal period. Babies born at home should be examined within 24 hours of birth by a GP and again a week or two later. The community midwife and health visitor should aim to give all parents, particularly first time parents, such additional care, encouragement and support as they may need and, by sharing professional knowledge and skills, help them gain confidence in caring for their baby. They should advise them of the importance of the baby receiving protection through immunisation programmes and regular developmental assessment. Health visitors should continue to assist each mother with advice on all aspects of her baby's care, on how to observe the baby's health and progress and how to recognise signs of potential illness such as excessive crying, cough, rapid or noisy breathing, irritability or unusual quietness in the baby, reluctance to feed, diarrhoea and vomiting. If babies show such signs, or exhibit changes in behaviour which worry their parents, the GP should be contacted without delay.

6.9 Whenever a mother sees the health visitor or doctor — at home, in the consulting room or at the clinic — she should be encouraged to discuss any worries she may have and to ask for advice on the care and handling of her baby. Mothers may well be the first to note a problem with their baby's development; any comments, questions or anxieties must be taken seriously. Child health clinics should have a homely and welcoming atmosphere where mothers can be encouraged to seek such advice without feeling inadequate or having their confidence in their own ability undermined and where they can meet other mothers with young children.

6.10 Tests to exclude the possibility of certain conditions such as phenylketonuria (PKU) and congenital hypothyroidism may be undertaken either

in hospital or at home; in either case the results should be notified to the GP and health visitor as soon as possible who should in turn tell the parents without delay. Any complications which arose while the baby was in hospital must be notified to the primary health care team so that they can plan his care accordingly. In particular any contra-indications to the usual immunisation programmes advised for babies should be clearly noted.

6.11 GPs and health visitors should be aware of the factors which are associated with the risk of unexpected deaths ("cot deaths") among babies in the first months of life. The health visitor will need to visit more frequently those mothers whose babies are regarded as at risk. Detailed attention should be paid to those babies' weight gain and to early symptoms of illness or signs that something may be amiss.

6.12 GPs and midwives caring for babies who have persistent or intensifying jaundice should have access to facilities for blood bilirubin measurement and should know whom they can consult so that appropriate treatment is provided in hospital when needed.

Postnatal examination

6.13 Each mother should have a postnatal medical examination at about 6 weeks after the birth. This will normally be undertaken by her GP unless there are reasons for her to go to hospital. The doctor who undertakes the postnatal examination should take particular note of the mother's rubella immunity status. The doctor should encourage the mother to talk about how she is feeling and coping with her family and the new baby, and also discuss her plans for future pregnancies informing her, if she wishes, of family planning facilities. The mother's obstetric record must be available for the examination.

6.14 Health visitors should be aware of the local arrangements for postnatal examinations and encourage each mother to attend. There should be a system for checking non-attendance and attempts must be made to persuade all women to attend. If necessary arrangements may have to be made to undertake this examination at home.

6.15 Because of the importance of the postnatal examination the clinic times should be flexible and convenient for mothers. If a hospital clinic appointment is made, written confirmation of the date should be given to the mother on leaving hospital.

Emotional needs and postnatal depressive illness

6.16 After the anticipation of pregnancy and the excitement of the baby's birth, a mother may later experience a sense of anticlimax and become irritable and depressed or resentful of the demands of her baby. The health visitor has a key role in helping her to understand that those feelings are not unusual. She should give encouragement to the mother, provide regular support by frequent visits during

this period and help her to seek the company of relatives and friends and self help groups.

6.17 If a mother does not respond to the advice offered, or if her partner, the health visitor or those close to her feel that there is cause for concern they should encourage her to seek advice at an early stage from her GP. If there is any suspicion that the baby may be at risk the procedures for dealing with child abuse should be brought into effect immediately.

6.18 The GP and health visitor must be alert to evidence of depression and signs of failure to form an emotional attachment to the baby, while recognising that delay is not uncommon especially when the baby has been separated from his mother for a significant period of time after delivery. Problems requiring special attention may not be evident until weeks or months after the birth of the baby and may present with physical symptoms or be concealed because of shame or guilt about such feelings. Although counselling or drug therapy may be effective, treatment should be directed at the salient causes, where these can be identified, and this may often involve participation of the mother's partner or immediate family.

6.19 Where the mother's condition or erratic behaviour suggests a diagnosis of puerperal psychosis, the most severe of the postnatal psychiatric illnesses, specialist help should be sought without delay. The family should be reassured that with modern therapy a complete recovery is likely.

6.20 Where admission to hospital is necessary mother and baby should be kept together where facilities permit unless the specialist considers that the mother's illness temporarily precludes her from caring for her baby. In such cases the doctor must ensure that alternative arrangements are made for the baby's care.

ACTION CHECKLIST E

MOTHERS AND BABIES AT HOME

E.1 Are the District's arrangements satisfactory for a mother's postnatal care at home?

E.2 Does the community midwife who will be responsible for a mother's postnatal care visit her during the antenatal period? Does the community midwife try to visit in hospital any mother who has to stay there longer than 5 days after delivery?

E.3 Are the methods of communication between hospital and community services adequate to ensure community midwives and health visitors are told of the advice given in hospital to individual mothers on infant feeding and postnatal care, so that they do not give conflicting advice?

E.4 Do community staff check that all mothers know how to recognise signs of complications in their own health? Are mothers advised when to call for help and from where this can be obtained?

E.5 Do GPs take steps to visit all recently delivered mothers at home?

E.6 Do all health visitors and midwives know how mothers can find out what practical help might be made available in the home if this is not forthcoming from family or friends?

E.7 Are all mothers encouraged to have a postnatal examination at about 6 weeks after delivery? Is there a system agreed locally for checking that all mothers are seen by a doctor? Are home visits arranged for those mothers who cannot or do not attend a clinic?

E.8 Are GPs, community midwives and health visitors aware of and alert to evidence of postnatal depressive illness and aware of the specialist help locally available should this be required?

E.9 If a mother requires treatment in hospital which precludes her from caring for her baby, are alternative satisfactory arrangements made for the baby's care?

E.10 Are all babies born at home examined within 24 hours of birth by a GP and again a week or two later? Are babies who have had only a first examination in hospital seen and assessed by their GP during the neonatal period?

E.11 Do facilities exist for GPs and community midwives to obtain blood bilirubin measurement?

E.12 Do mothers know where at all times they can get advice about infant feeding? Are parents encouraged to discuss any worries they may have about their baby with their health visitor and GP? Is practical written information available to all mothers on infant care?

E.13 Is a mother who is concerned about the health of her baby able to obtain the advice of her GP quickly?

E.14 Are the results of all tests carried out on the baby notified to the GP? Are the parents always informed of the results without delay?

E.15 Do health visitors, in advising mothers on their baby's care, ascertain that they know how to keep him at a safe and comfortable temperature, how to ensure he is receiving adequate nourishment, when to start taking him out and how to deal in general terms with crying, sleeping problems, colic and rashes?

E.16 Do doctors and health visitors advise mothers in the recognition of signs which may indicate serious illness in the baby? When these signs are present are mothers advised to seek professional advice without delay?

E.17 Are parents given details of local child health and developmental clinics? Are clinic sessions timed so that they provide a choice for parents and are they arranged to coincide with other clinic services the mother may wish to use on the same visit?

E.18 Are there clearly understood local procedures to be followed in cases of suspected or actual child abuse?

E.19 Has considereation been given to providing parents with a self completion child health record, including a weight chart?

E.20 Have special procedures been agreed locally for monitoring the progress of babies who may be at risk of unexpected infant death? Are health professionals aware of the up-to-date information available from organisations such as the Foundation for the Study of Infant Deaths? Are health visitors provided with percentile weight charts and portable scales for weighing such babies at home?

CHAPTER 7: STILLBIRTHS AND NEONATAL DEATHS

Policy statement

7.1 The death of a baby is deeply distressing to parents and the attitude of doctors, nurses and midwives will be crucial in helping the parents come to terms with their loss and grief. The education and training of all staff caring for the parents should enable them to respond to the parents' needs and to cope with the distress that they themselves may feel. They must be careful not to avoid parents but at the same time recognise their need for privacy to grieve the loss of their baby and to make the decisions which the events following a death require.

7.2 Parents should be given as much information as possible on the cause of their baby's death, be encouraged to discuss it and advised of any implications for the future.

Death occurring in pregnancy

7.3 When the death of a baby "in utero" is first suspected staff attending the mother or carrying out investigations should be wary of raising unjustified anxieties or hopes in the mother. Once such a diagnosis has been firmly established however the mother, together with the baby's father whenever possible, should be told in private. Staff should assess how much information to give when breaking the news and ensure that all available information is provided as soon as the parents are prepared for it.

7.4 The mother should be told how the delivery of the baby will be managed and, if maceration or a fetal abnormality is anticipated, parents should be forewarned. The facts, however harsh, are usually kinder than the parents' imagination.

7.5 During the delivery of an anticipated stillborn baby, the support of the father or a friend will be especially important to the mother and should be encouraged. The senior midwife on duty should decide who is the most appropriate midwife to be in attendance. If possible, the mother should be cared for by one or two members of staff who have come to know the parents and be able to offer them the extra support needed at this time.

The dying baby

7.6 Parents of a baby born with severe abnormalities which are incompatible with life or of a baby likely to die soon after birth, should be given every opportunity and encouragement to stay with him until he dies and to participate actively in the care that can be provided. A room should be available where they can look after him in private but staff familiar to them should continue to provide support and advice. A dying baby should be kept as comfortable as possible and given the same general

care as any other baby. Facilities should be provided for parents to have their baby christened if they wish or to observe any other religious custom.

7.7 In those few cases where the death is certain and unavoidable parents should be able to take their baby to die at home if they prefer; in these circumstances staff should ensure that there is adequate liaison with the primary care team at home, and advise parents where they can get help if this is needed and of the procedures required after death.

Immediate support and advice to parents whose baby dies

7.8 Whatever the circumstances of a baby's death, the parents' grief may be assuaged if as much information as possible is given to them honestly and openly at the right moment; they may become suspicious and resentful if they feel information was withheld from them or has been inconsistent. In giving information, staff should recognise that both parents may not face the situation and go through the stages of the grieving process at the same time and that the strength of one often supports the other.

7.9 Parents who have suffered the death of a twin may experience conflict within themselves between their feelings for the surviving baby and the need to mourn their loss. These parents should be given as much support and opportunities for discussion about their conflict and loss as other bereaved parents.

7.10 Most parents will be helped by seeing and holding their dead baby but may need encouragement and reassurance in doing so. If it is the wish of the parents, close family members should also be able to see him. If the baby has a severe abnormality, or is macerated, particular care in wrapping and presenting the baby to the mother and other members of the family will be needed. Unless the parents object, a good quality colour photograph should be taken of the baby and if the parents initially do not wish to see this it should be kept in the baby's records folder in case they ask for it later.

7.11 As soon as possible, particularly when the death was unexpected, the parents should be seen by the consultant obstetrician who was responsible for the mother's care and in the case of a neonatal death by the consultant paediatrician. A record of the discussion with the parents should be included in both the mother's and baby's notes.

Establishing the cause of death

7.12 A post-mortem examination should preferably be performed following every stillbirth or neonatal death, but no such examination should be carried out without a parent's consent unless required by the Coroner in which case the parents should be so informed. The request to undertake such examination should be made only by a doctor who has already established contact with the parents before their baby's death, and who can explain clearly that the importance of this examination is

not only to provide medical knowledge but to give the parents themselves any additional information that may be revealed about the cause of their baby's death and any implications for future pregnancies.

7.13 The standard of a perinatal post-mortem examination should be high. The cause of death as stated in the death certificate should be as accurate as possible and for those deaths occurring in consultant units, completion of the death certificate should be undertaken by or under the guidance of the senior doctor. Each Region should examine the adequacy of its perinatal pathology service. In meeting any identified deficiency, each Regional Health Authority should consider the appointment of at least one experienced pathologist with expertise and interest in perinatal pathology, who would provide a consultative and teaching role for other pathologists in the Region.

7.14 The results of any post-mortem examination should be discussed as soon as appropriate with the parents and any item of importance arising from the discussion should be recorded in the mother's notes, cross referenced to the baby's notes.

Registration of stillbirths and neonatal deaths

7.15 Each unit's policy concerning stillbirths and neonatal deaths should clearly outline the different procedures for registering a stillbirth and for registering the birth and death of a liveborn baby. A senior member of staff should explain the appropriate procedure to parents and in particular they should be advised that the stillbirth certificate issued to them by the Registrar of Births and Deaths, can on request, include the chosen name of their stillborn baby.

Burial or cremation

7.16 The appropriate procedures and arrangements for burial or cremation should be known to staff and written information should be provided for parents. This should explain how parents can make their own arrangements, the likely costs, and the amount of death grant they may be able to claim. It should describe the arrangements the hospital can make if parents find the costs beyond their means, and the practical assistance it can provide in transferring the baby to the parents' home area, if he was stillborn or died in a hospital outside that area.

7.17 A member of staff familiar with local arrangements should be designated as a central point of contact to whom parents can turn in the first instance for help and advice. Hospital arrangements for the burial or cremation of a stillborn baby or a baby who dies shortly after birth should be dignified and involve a simple ceremony if the parents wish. The site of burial should ideally be a designated, well kept area. Parents' wishes for any religious observances on death and attendance by relatives or friends should be facilitated.

Leaving hospital

7.18 The timing of the mother's return home should be considered as soon as possible. Some mothers may prefer to return home immediately but if a mother requires a longer stay she should be offered accommodation apart from mothers with babies. A midwife should retain responsibility for the mother's postnatal needs wherever she is accommodated.

7.19 Before going home a mother should be given the opportunity to discuss the problems she is likely to encounter such as explaining events to her other children, talking to friends and relatives, giving or putting away baby clothes and toys and her reactions when she sees other mothers with their babies.

7.20 The GP, community midwife and health visitor must be informed immediately of a stillbirth or neonatal death and the circumstances. They will need to visit as soon as the mother comes home but may in the meantime meet members of the family.

7.21 Every encouragement should be given to a mother whose baby has died to have a postnatal examination either by her GP or at a hospital clinic. She should not be asked to attend a routine postnatal clinic where she will be surrounded by other mothers with their babies. Parents should be offered the opportunity to review the events of the pregnancy and delivery or subsequent neonatal problems, with the consultant obstetrician or paediatrician, as appropriate, and to discuss any information which may have become available.

Staff needs

7.22 Although the training of all hospital staff should help them to respond to parents' reactions and needs and to cope with their own feelings, senior medical and midwifery staff should ensure that there are sources of effective counselling and support available particularly for students and for any member of staff who becomes unduly distressed or depressed.

Longer term support and advice needed by parents

7.23 The suppression of emotional reactions can lead to difficulties later and parents should be encouraged to express their feelings and talk, if they wish, to hospital staff, to their GP, community midwife or health visitor as well as to relatives and friends. They may also benefit from the support offered by voluntary organisations.

7.24 If the baby's death was due to any genetic disorder the parents should be given the opportunity of specialist genetic counselling.

Review of stillbirths and neonatal deaths

7.25 When a stillbirth or neonatal death occurs the consultant or GP in charge should review the circumstances as soon as possible with all the staff concerned to ensure that the case is properly documented. Each unit should arrange for a regular clinical review of perinatal and neonatal mortality within the period of ready recall of the event by staff concerned. The outcome of this review may be used to give further information to parents about their own loss.

Collation of statistics

7.26 As a basis for improving standards and to assist clinicians in the assessment of their practice, each Regional Health Authority should adopt, in consultation with its District Authorities and clinicians concerned, a system for collecting data on antepartum and intrapartum stillbirths, early and late neonatal deaths and the outcome for different levels of neonatal care. These data should be made available on a regular and timely basis. They should identify death rates by different birthweights and different gestational ages, by malformations and from other causes together with relevant information concerning the mother, her health and any complication during pregnancy or childbirth. These statistics will need to be related clearly to total births in defined populations to allow valid comparisons between Districts and between neonatal units.

7.27 District Health Authorities should keep the performance of their own units under constant review and request the Maternity Services Liaison Committees to examine further any unusual features.

ACTION CHECKLIST F

STILLBIRTHS AND NEONATAL DEATHS

F.1 Do senior staff check periodically that staff are giving adequate support to parents who have suffered a stillbirth or neonatal death? Do they give special attention to the needs of members of staff who become unduly depressed or distressed by deaths in the unit?

F.2 Are parents given as much information as possible on the cause of their baby's death and encouraged to discuss the circumstances with the consultant obstetrician and paediatrician concerned, as appropriate, and implications for future pregnancies?

F.3 Where death is certain and unavoidable is there a plan for the care of the dying baby which takes into account his needs and the parents' wishes?

F.4 Is a room provided where bereaved parents can be alone with their baby and for private discussion? Is suitable accommodation offered to those mothers who are unable to leave hospital straightaway?

F.5 Are bereaved parents given the opportunity of counselling and spiritual help?

F.6 Are facilities made available in hospital for any religious observances to be carried out?

F.7 Are there facilities for a good quality colour photograph to be taken of the baby?

F.8 Are there copies of the Health Education Council's booklet "The Loss of Your Baby" available to be given to parents? Are parents told about the support offered by similarly bereaved parents through such groups as the Stillbirth and Neonatal Death Society?

F.9 Is there a recognised procedure for the mother's GP, community midwife and health visitor and the antenatal clinic, if appropriate, to be informed immediately of the stillbirth or early neonatal death and the circumstances?

F.10 Are mothers given the opportunity to discuss the problems they are likely to encounter on return home? Is information available on benefits and entitlements?

F.11 Are special arrangements made if the mother is to return to the hospital for her postnatal examination? Are arrangements made for the parents to return to the hospital for discussions with the consultant obstetrician or paediatrician as appropriate? Has the possibility of home visits been considered?

F.12 Are parents given the opportunity of specialist genetic counselling, if appropriate?

F.13 Is the importance of a post-mortem examination clearly explained to the parents by a doctor already known to them?

F.14 Is the protocol of the Paediatric Pathology Society or other similar comprehensive guidance available for those undertaking post-mortem examinations? Is the perinatal pathology service kept under review? Are

pathologists with expertise and interest in perinatal pathology encouraged to provide a consultative and teaching role for other pathologists in the Region?

F.15 Are the results of post-mortem examination discussed fully with the parents as soon as appropriate?

F.16 Does each maternity unit's written operational policies cover registration procedures to be followed for parents whose baby was stillborn or has died shortly after birth?

F.17 Are parents given written information on the arrangements that can be made for the burial or cremation of a baby who was stillborn or who died shortly after birth? Is there a designated member of staff to whom parents can turn for advice?

F.18 Are hospital burial or cremation arrangements properly explained; are they dignified and is a simple ceremony held if parents wish?

F.19 Does each unit have an agreed procedure for reviewing events after a stillbirth or neonatal death? Is an early review carried out by the consultant or GP in charge? Is there a regular system of professional enquiry when all the relevant information is available?

F.20 Are up-to-date statistics on the incidence of stillbirths and neonatal deaths and the outcomes of different levels of neonatal care collected for each unit in each District as recommended in the chapter? Do Regional Health Authorities collate and provide District Authorities with such information on all units in the Region together with information on the characteristics of the population served and do District Health Authorities keep the performance of their own units under review?

CHAPTER 8: STAFFING FOR POSTNATAL AND NEONATAL CARE

Introduction

8.1 The ability of Regions to meet the standards set by this report will vary and depend on a number of local factors. Nevertheless some of the standards are the minimum which every Region should seek to meet. Other guidance is offered as advice to Health Authorities on desirable practice and to assist them in the task of assessing requirements and raising standards of care.

8.2 Staffing requirements for postnatal care are determined by the needs of both mothers and their babies.Some mothers will be recovering from an operative delivery or other complications, or will be ill, and will require care for themselves and help with their babies. Most other mothers will care for their babies themselves, although they will need to have their skills and feelings of competence built up by midwifery staff especially if they are first time mothers. The benefits of caring for babies who have had complicated deliveries and need close observation, as well as others requiring treatment such as phototherapy, beside their mothers are increasingly recognised. This will necessitate enhanced staffing in the areas used for postnatal care.

8.3 Staffing for neonatal care will be determined by the type and level of care to be provided in a particular neonatal unit and the degree of special care that can be provided for babies with their mothers in the areas used for postnatal care. All but the smallest maternity unit should be expected to provide a measure of short term intensive care for small and ill babies born there, at least until they can be transferred to a Regional Perinatal Centre if this is required. Because of developments in obstetric and paediatric practice there is likely to be an increasing number of very small babies surviving with the help of long term intensive care. The provision of this long term care should be developed in accordance with the Regional strategy. As Districts develop their capacity to care for small and ill babies Regional Perinatal Centres can be expected to become increasingly and mainly concerned with the most demanding cases.

Midwifery staffing for postnatal care

8.4 Within each consultant and GP maternity unit there should always be sufficient midwives to provide postnatal care and support for mothers and to undertake any additional treatment and care required by their babies. Midwives responsible for such care should have ready access to expert advice and assistance from the medical and neonatal nursing staff of the appropriate neonatal unit.

8.5 All midwifery staff working in consultant or GP maternity units should have the opportunity of work experience in all aspects of maternity care, including postnatal care. Planned rotation of staff through all departments, including

experience in the community, is desirable. By these means heads of midwifery services will have the flexibility needed to provide mothers and babies with a greater measure of continuity of care and to meet peaks of demand as they arise.

Midwifery and nursing staffing for neonatal units

8.6 Each neonatal unit should have a separately identified midwifery and nursing establishment that takes account of its assessed workload, having regard to:

- the number of births expected;
- an assessment of the proportion of babies born with conditions that make it unlikely they could be cared for with their mothers in areas used for postnatal care;
- the level of intensive care the unit is expected to provide within the Region's strategy;
- the need to care for babies remaining in the unit after a period of intensive care;
- the need to provide postnatal care for mothers residing in the unit.

8.7 The following criteria should also be taken into consideration:

- in every neonatal unit there should be at any one time a nurse in charge who has at least one year's experience in neonatal nursing;
- every neonatal unit should have at least two nurses on duty at any one time (including the nurse in charge) who are able to resuscitate babies;
- the duties of nursing staff in each unit should rotate between night and day duty;
- for babies requiring intensive care one nurse should not be expected to care for more than two babies at any time. The condition of some babies will require a ratio of one nurse for each baby;
- each nurse giving intensive care should be experienced in neonatal care and preferably have completed a recognised post-basic training course;
- in Regional Perinatal Centres clear arrangements should be made to ensure the availability of a trained nurse to accompany a baby who needs to be brought into the Centre in an emergency without seriously altering the ratio of nurses required to look after the babies already in the unit;
- staff giving intensive care should have periodic relief from the intensity of their work and be given time off for learning opportunities such as attending seminars and to visit other neonatal units.

Nursing establishments should be kept under periodic review to take account of changing demands and any changes in the type of care given in the unit. Any

significant inability or delay in filling posts which places unreasonable stress on the staff on duty, together with recommendations to relieve the situation, should be reported to the unit management to consider what action can be taken.

Midwifery and health visitor staffing in the community

8.8 Each District should have sufficient midwives and health visitors to ensure that all mothers are visited at home on a regular basis and as required. Where a maternity or neonatal unit has an agreed policy of early transfer home of babies who have been receiving special care, managers of community midwifery and health visiting services should see that sufficient numbers of their staff are skilled, and trained, to provide additional support and care for such babies at home.

Medical staffing for postnatal care

8.9 The obstetric staffing of consultant units should provide 24 hour cover for mothers who develop postnatal medical complications. The organisation of duties should ensure that postnatal care of mothers, including the examination and assessment for return home when necessary, can be undertaken without delay.

8.10 In GP units 24 hour medical cover during the period immediately after childbirth is the responsibility of the GP concerned, and he or a nominated deputy should be available for any necessary examination to enable the mother and baby to leave the unit as soon as they are ready. The mother should, if she has delivered as planned at home, look to her GP to provide postnatal care.

Medical staffing for neonatal care

8.11 All consultant maternity units should have 24 hour medical cover for the care of the newborn. This should be provided by a paediatrician, ideally on site, available to attend promptly when required. Obstetric and midwifery staff should be appropriately trained to resuscitate babies. Future hospital planning, in bringing obstetric and paediatric facilities together on the same District General Hospital site, should ensure that a paediatrician will be available to attend at once.

8.12 A neonatal unit, associated with a consultant maternity unit, should only undertake continuing responsibility for small or ill babies who require prolonged intensive care if an experienced resident paediatrician and consultant cover are available at all times.

8.13 In Regional Perinatal Centres resident paediatricians should not have responsibilities elsewhere which conflict with providing medical cover for the neonatal unit. A trained paediatrician must be available at all times for the transfer in of small or ill babies. Such centres should have in charge at least one consultant perinatal paediatrician supported by sufficiant other consultant cover to provide the clinical service and to meet the requirements imposed by the need for training and

research. In the busier Regional Perinatal Centres the support of at least one additional colleague with a similar clinical commitment will be needed. There should be sufficient resident medical staff to maintain the standard of neonatal care throughout the 24 hours.

Stress in neonatal units

8.14 Stress can occur among staff providing intensive care for small and ill babies. Senior staff should endeavour to anticipate stress and its likely causes so that they can take preventive action. Staff will usually feel more confident if they work as a team with clearly understood operational policies and have regular meetings to discuss stressful situations and problems as they arise. If possible the opportunity should be made available for occasional relief from sustained and intolerable stress. Stress will be exacerbated by a high work load and insufficient staff, and senior staff should watch that high motivation however commendable does not lead staff to work hours grossly in excess of their normal duty. All staff new to a neonatal unit should have a period of orientation.

Support services

8.15 There should be an adequate level of clerical, domestic and housekeeping support to all areas used for postnatal care and in the neonatal unit. There should be clearly understood arrangements on how to obtain advice and assistance from physiotherapy and other specialist services as required.

8.16 Every maternity unit should be able to call on the services of a social worker and in some of the larger units he or she might be based in the maternity or neonatal department.

Education and training

8.17 As part of its agreed strategy for neonatal care each Regional Health Authority should agree with its District Health Authorities a nurse training plan which should aim to meet the foreseeable requirements of the Region as a whole for nurses skilled in the intensive care of the newborn; those midwives and nurses already in post who have not had this training should be encouraged to acquire it. Midwives and nurses who are required to look after babies needing extra care may need additional training which Health Authorities should facilitate. Districts should ensure that they have a continuing programme of in-service training which provides for attendance by experienced staff at updating courses and visits to other units to broaden their experience. Particular attention should be paid to the selection of nurses for training and subsequent opportunities for their development and promotion to ensure that as far as possible trained nurses are encouraged to remain in the specialty.

Staffing and planning implications

8.18 Health and Local Authorities and bodies concerned with training should take these staffing needs into account and keep them under frequent review.

ACTION CHECKLIST G

STAFFING

G.1 Is there at all times a midwife in charge of each area used for postnatal care?

G.2 Are all midwifery staff in the maternity unit positively encourage to work in postnatal care, as well as in the delivery suite, antenatal clinics and in the community?

G.3 Are midwifery staffing levels kept under review to take account of the need for babies whenever possible to be cared for alongside their mothers rather than being admitted to a neonatal unit and to ensure that mothers and babies receive the care that they both need?

G.4 Are midwives given additional training if required for the special care of babies in areas used for postnatal care?

G.5 Is there always a doctor available for postnatal care and to carry out examinations promptly to enable mothers and babies to go home as soon as they are ready?

G.6 Is there a separately identified midwifery and nursing establishment for each neonatal unit? Does this take into account the level and type of care the unit is expected to provide as part of the agreed Regional strategy for neonatal care and does it assume that babies will whenever possible be cared for alongside their mothers in areas used for postnatal care? Is the staffing establishment kept under review?

G.7 Is there at all times an appropriately experience nurse in charge of the neonatal unit? Is there an agreed minimum of nurses required to be on duty in the unit at any one time?

G.8 Does the neonatal unit's midwifery and nursing establishment take account of the need for staff to undertake day and night duty, and for the relief of stress to undertake duties elsewhere? Do staff have opportunities to take time off to attend seminars and to visit other units?

G.9 Do all consultant maternity units have 24 hour medical cover for the care of the newborn? If a paediatrician is not available on site at all times are obstetric and midwifery staff appropriately trained to resuscitate babies and to give emergency care until expert paediatric care can be provided?

G.10 Does each Regional Perinatal Centre have in charge a consultant perinatal paediatrician? Is there sufficient support from other consultants to ensure the service, training and research needs of the Centre? Does the staffing of Regional Perinatal Centres include sufficient resident paediatric staff able to maintain the standard of neonatal care throughout 24 hours? Are a doctor and a nurse always available for the transfer in of babies referred to the Centre for intensive care?

G.11 Are the reasons for staff vacancies examined? Are existing staff encouraged to stay through opportunities for career development and promotion?

G.12 is provision made for staff of the neonatal unit to give expert advice and support to community midwives and health visitors responsible for babies who have continuing special care needs?

G.13 Are regular meetings held for all the staff on the neonatal unit to discuss the work of the unit and situations which may be giving rise to stress? Do senior staff endeavour to anticipate stress and its likely causes and take preventive action?

G.14 Do each maternity unit's written operational policies state clearly what service is available from other hospital departments and fom the Local Authority Social Services Department, and how these services can be obtained?

G.15 Are levels of clerical and other support services kept under review?

G.16 Are staffing levels in the community midwifery and health visiting services kept under review?

G.17 Is a programme for nurse training in neonatal care being developed as part of the Region's strategy? Does this aim to meet the Region's foreseeable nurse staffing requirements for the provision of intensive care?

G.18 Do Health Authorities keep all training needs under review?

G.19 Do Health Authorities review with Local Authority Social Services Departments the need for social work staff for maternity and neonatal care?

CHAPTER 9: DESIGN AND EQUIPMENT

Introduction

9.1 To facilitate good practice in postnatal care and care of the newborn, the following principles should be built into the design of any new maternity and neonatal unit, and, as far as practicable in any upgrading of existing buildings. Doctors and nursing staff should be involved in discussions from the initial planning stage. The Chapter also includes advice on the medical and nursing equipment of such units for postnatal and neonatal care. The Department of Health is at present revising its Health Building Note 21 on the Maternity Department which will contain detailed building and engineering design guidance together with cost allowances.

I: Areas used for postnatal care

Siting

9.2 Maternity departments should be located so that the quantity of accommodation can be altered to meet changing demand. The areas used for postnatal care should be sited within easy reach of the delivery suite and close to the neonatal unit.

Design philosophy for postnatal care

9.3 To the extent that the majority of newly delivered mothers and their babies are healthy, their care needs are different from those of hospital in-patients. They will often only stay in hospital for a short time before returning home and may need rest during this period. The need is for a friendly relaxed environment in which their babies will be with them or near them most of the time. Accommodation need not be designated for postnatal care only. The design should allow for the accommodation of both antenatal and postnatal mothers in the same area, but not within the same room.

Size and design of accommodation for postnatal care

9.4 The size and design of rooms used for postnatal care should allow for the adequate supervision of mothers and babies at all times. Single rooms should be provided for mothers wishing to be alone or requiring special care or treatment, the

number depending on the design of accommodation and assessment of likely needs. Shared rooms should have curtains around each bed to allow individual privacy when required. All rooms should be carpeted, suitably furnished and attractively decorated. Windows should provide adequate natural daylight and ventilation and have curtains or shades.

9.5 Adequate space should be provided in each bedroom for babies to be nursed alongside their mothers, including those needing extra care and treatment. Every bedroom should have piped oxygen and outlets for suction and each bed-head should have sufficient electrical sockets for the portable equipment needed for treatment purposes. There should be room also for at least two visitors to sit.

9.6 There should be sufficient toilets, bidets, baths and showers within each area. At least two single rooms should have toilets and baths or showers ensuite in case isolation nursing facilities are required.

Sitting room

9.7 There should be a conveniently sited general sitting room for mothers to receive visitors. Smoking should be actively discouraged, and not permitted in areas where there are babies or which are occupied by mothers who do not smoke.

Separate facilities for babies

9.8 In each area used for postnatal care one of the single rooms should be so designed that it can, on occasions, be used to accommodate those few babies who need to be removed temporarily from their mother's bedside. This room should have an observation window and be sited close to the nursing station.

Consultation and examination room

9.9 A consultation and examination room should be provided. This could be shared between two areas on the same floor, but should not be used routinely for other purposes.

II: Neonatal units

Size and design of neonatal unit accommodation

9.10 There should be adequate space around each cot in the neonatal unit to reduce the risk of infection and to allow the baby's parents and staff to have access to him without obstruction. At least one room in the unit should be designated for isolation purposes.

9.11 Sufficient electrical sockets, piped oxygen and air, suction outlets and shelving should be provided by each cot so that special treatment and intensive care can be initiated and maintained if required. The number and loadings of electrical sockets, which should not be underestimated, should be discussed with the professions involved at an early stage in a unit's design.

9.12 There should be an adequate number of conveniently sited and recessed wash-basins with elbow operated taps to reduce the risk of contamination of handles. Surfaces within the unit should be easy to keep clean and free from dust. The possibility of being able to close part of the unit for cleaning and disinfection and yet remaining operational should be considered. Floors should be smooth, hard-wearing and easy to maintain. There should be facilities for cleaning and disinfecting all equipment used. Air-conditioning should be provided and the temperature and humidity should be accurately controllable and respond promptly. Heat gain or loss through windows should be minimised.

9.13 Accommodation should be provided within or adjacent to each neonatal unit for mothers and fathers who need to stay overnight. A quiet, suitably furnished room should be available for parents to be with their dying baby or to be alone for a while after his death. Facilities should be available for parents and staff to prepare light refreshments when other hospital facilities are closed and there should be a sitting room area near to the unit for parents' use.

III: General

Demonstration and teaching room

9.14 One or more rooms should be available in areas used for postnatal care and the neonatal unit for teaching purposes and where staff can hold parentcraft and health care sessions.

Milk room and milk bank

9.15 There should be separate accommodation equipped and used for the preparation of feeds and for the storage of breastmilk, infant feeds, teats and breast pump accessories. Breastmilk banks should be provided only if adequate facilities are available, either on or off site, for microbiological and chemical analysis and there should be adequate space and equipment for testing, labelling and storage.

Storage facilities

9.16 Adequate storage space should be provided in each area used for postnatal care and in the neonatal unit for equipment and cots as well as for linen, disposables, sterile supplies, drugs and surgical stores. Only supplies for immediate use should be

kept on the units. Dirty utility and waste disposal facilities must be sited centrally but with easy access for the collection of waste.

Staff facilities

9.17 All neonatal units and areas used for postnatal care should have conveniently sited toilet and changing facilities for staff. In addition to the overnight accommodation provided for doctors within the maternity unit, accommodation, with toilet and shower, should be provided within the neonatal unit for paediatricians on call so that they can be immediately available. A sitting room should be available for staff to use during their breaks.

Office accommodation

9.18 Medical and nursing staff as well as social workers and clerical support staff will need adequate office accommodation in each area used for postnatal care and in the neonatal unit.

IV: Equipment

9.19 Medical and nursing equipment for postnatal care of mothers and normal care of their babies should include:

- resuscitation equipment for mothers
- a resuscitation trolley for babies
- an incubator
- a socket suitable for use by mobile X-ray machine
- X-ray viewing boxes
- breastpumps
- weighing scales for babies.

9.20 For neonatal units providing the full range of intensive care facilities, the following equipment recommended as a minimum provision by the British Paediatric Association should be provided for each baby receiving intensive care:

- an incubator
- a respiratory monitor
- a heart rate monitor
- an intravascular blood pressure transducer or surface blood pressure recorder
- a transcutaneous PO2 monitor or intravascular oxygen transducer
- two syringe pumps
- two infusion pumps
- a ventilator
- a continuous temperature monitor

— a phototherapy unit
— an ambient oxygen monitor
— facilities for blood gas analysis using micromethods
— facilities for bio-chemical analysis by micromethods.

In addition the unit should have access to ultrasound equipment and equipment for radiological examination.

9.21 Due to the advances in neonatal intensive care over recent years this list will have to be closely and frequently reviewed and have regard to up-to-date information from the British Paediatric Association and other appropriate professional bodies.

9.22 The equipment needs of other neonatal units will vary according to the level of care they are to provide and it will be for units to determine which of the above items of equipment are appropriate.

9.23 Equipment must be adequately maintained and serviced and there should be a workshop near to the unit where running repairs can be carried out. There should be a well defined policy for the identification, inspection and repair of faulty equipment used on the unit.

CHAPTER 10: IMPLEMENTATION

10.1 This report and the Maternity Services Advisory Committee's previous two are intended as practical guides to be used by Health Authorities to raise standards of care, in spite of limited resources. Taken together they cover the whole field of maternity and neonatal care. In order to help Authorities start work early in appraising current practice, it has been necessary to break up the Committee's work into the stages of the three reports. Authorities should however keep the services under review as a whole.

10.2 The questions in the checklists used in conjunction with the text provide a basis for Maternity Services Liaison Committees to regularly monitor and improve the service. The questions should be asked at appropriate intervals, their implications fully considered and be carefully answered. As practice and the service develops Maternity Services Liaison Committees should extend the checklists as required.

10.3 The need for Maternity Services Liaison Committees is again emphasised. The terms of reference for the Committees have been clearly set out. They should make regular reports and advise management where services are deficient and recommend in the light of local circumstances how current practice should be improved. In addition to their specific functions they will as a result of this report have the task of reviewing Districts' progress in realising the objectives of the Regional strategy for the provision of neonatal intensive care and its associated programmes.

10.4 It is the responsibility of Health Authorities to monitor carefully the way the advice of their Committees is put into effect at all levels. They must work closely with Family Practitioner Committees, Local Authorities, Community Health Councils and other representative interests.

10.5 Good practice in maternity care depends as much on the way professional people can work together as on the separate skills of the professions involved. Maternity Services Liaison Committees must work to secure an integrated approach to maternity care, and encourage multidisciplinary education. But whatever standard of professional skill is achieved the service will be less than satisfactory if it does not also embrace the viewpoint of parents, the welfare of the family and above all the interest of the baby.

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